



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

September 5, 2003

FOR: FOOD STAMP CERTIFICATION MANUAL DISTRIBUTION

FOOD STAMP CERTIFICATION MANUAL – VOLUME V

TRANSMITTAL #57

This transmittal contains clarifications and changes for the Food Stamp Program. The transmittal also contains annual revisions to the income guidelines, allotment charts, utility and telephone standard amounts, and standardized amounts for day care providers. In addition, there are changes to the standard deductions and the maximum shelter deduction.

The transmittal also contains policy provisions authorized through the Food Stamp Reauthorization Act of 2002. These provisions change food stamp eligibility for immigrant children under 18 years of age by eliminating the evaluation date of August 22, 1996, and by excluding children from the sponsored immigrant policies.

The provisions of this transmittal are effective for eligibility determinations for October 1, 2003.

Guidance for maintenance of the manual follows. The manual and this transmittal are available on the Internet at http://www.dss.state.va.us/benefit/fs_manual.html and on the Intranet at <http://www.localagency.dss.state.va.us/division/bp/fs/manual.cgi>.

Remove Page(s)	Insert Page(s)	Significant Changes
Part I Pages 1-2	Part I Pages 1-2	A restriction was added for converting food stamp benefits to coupons. The agency may not convert benefits for households moving to Puerto Rico.

Remove Page(s)	Insert Page(s)	Significant Changes
Part II Pages 9-10	Part II Pages 9-10	The requirement to contact other states was changed so that workers no longer need to determine prior participation for countable Work Requirement months in other states.
Part VI Pages 3-4	Part VI Pages 3-4	The income limits were increased to determine separate household composition status for disabled, elderly people.
Pages 7-8	Pages 7-8	The minimum amounts needed to determine boarder status were increased.
Part VII Pages 9-10	Part VII Pages 9-10	The conditional eligibility requirements for qualified immigrants were changed. This is the final provision of the 2002 Farm Bill to be implemented for immigrants. Qualified immigrant children who are under 18 years of age will be eligible for food stamps regardless of the date of entry into the country.
Part X Pages 1-6	Part X Pages 1-6	<p>The standard deductions were revised for households with five members or more. The amounts for households with fewer members did not change.</p> <p>The maximum shelter deduction changed from \$367 to \$378.</p> <p>The standard utility allowances were changed from \$194 and \$240 to \$206 and \$253 for households with one to three people and for units with four or more people, respectively.</p> <p>The telephone standard was increased from \$43 to \$51 for households using actual utility</p>

Remove Page(s)	Insert Page(s)	Significant Changes
		expenses or for households ineligible for the standard utility allowance.
Part XI Pages 1-2	Part XI Pages 1-2	The maximum gross and net amounts for income eligibility were changed,
Part XII Pages 5-8	Part XII Pages 5-8	The allowances for meals used to determine the countable income of day care providers were revised.
		The exclusion section of the sponsored immigrant policy was changed to include immigrant children. This means that workers will not have to count the income and resources of the sponsor and the sponsor's spouse as that of the sponsored immigrant.
Pages 21-22	Pages 21-22	Transitional Benefits policy was clarified to indicate that households may elect to receive regular food stamp benefits instead of Transitional Benefits before the conversion actually occurs. After assignment to Transitional Benefits, households must reapply to end Transitional Benefits to return to regular benefits.
Part XIII Pages 1-2	Part XIII Pages 1-2	A clarification was added to the household composition section to require a re-evaluation of a person's immigration status after reaching the 18 th birthday for a child previously determined eligible.
Part XIV Pages 1-4	Part XIV Pages 1-4	The reporting requirement income limits were changed to the new limits.

Remove Page(s)	Insert Page(s)	Significant Changes
		A clarification was added to note that households must verify elements at recertification or when the household submits the Interim Report.
Part XV Pages 1-2	Part XV Pages 1-2	A clarification was added to the Work Requirement policy to note that only participation in Virginia will count toward the 36-month period and the 3-month limit on benefits.
Part XIX Appendix I Pages 1-6	Part XIX Appendix I Pages 1-6	The names, addresses, telephone numbers and areas served for legal assistance were revised.
Part XXIII Entire Chapter	Part XXIII Entire Chapter	The allotment tables were revised.
Part XXIV Pages i-ii Pages 1-18	Part XXIV Pages i-ii Pages 1-18	The Table of Contents was revised. The application was revised to address languages spoken by households, expanded race codes and children's health questions.
Pages 27-30	Pages 27-30	The revised evaluation form has minor stylistic changes.
Pages 35-36	Pages 35-36	The hotline flyer was changed to include revised legal assistance addresses.
Pages 50-51	Pages 50-51	The advance notice was changed to include a revised effective date for TANF and VIEW purposes.

Remove Page(s)	Insert Page(s)	Significant Changes
Pages 56-57	Pages 56-57	The Change Report form was revised to include new income limits and a household composition element for reporting when eligible children leave the home for TANF purposes.
Pages 68-69	Pages 68-69	The action request form for the Interim Report form was revised to delete a specific statement about verifying income for working members for households that fail to submit it Interim Report timely. Households will need to verify all earned income sources for the Interim Report however.
Pages 81-82	Pages 81-82	The communication form was revised with minor stylistic changes.
Part XXV Appendix III Page i	Part XXV Appendix III Page i	The Table of Contents was revised.
Pages 10-11	Pages 10-11	The Plan of Participation form was revised to indicate no supportive services.
Pages 37-38	Pages 37-38	The communication form was revised with minor stylistic changes.



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Attachment

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VOLUME V, PART I, PAGE 1

A. PURPOSE OF THE FOOD STAMP PROGRAM

The purpose of the Food Stamp Program is to alleviate hunger and malnutrition. The Program will meet its goals by permitting low-income households to obtain a more nutritious diet through normal channels of trade by increasing the food purchasing power for all eligible households who apply for participation. The U.S. Congress intended to promote the general welfare and to safeguard the health and well being of the population of the Nation by raising levels of nutrition among low-income households. The intent is also to help provide food in cases of emergency and financial disaster.

The purpose of this manual is to provide the local welfare/social service agency with certification procedures. Regulations for the issuance of Electronic Benefit Transfer (EBT) cards to eligible households are in the Virginia Electronic Benefits Transfer Policy and Procedures Guide.

B. HISTORY OF THE FOOD STAMP PROGRAM

The Food Stamp Act of 1964 authorized the Food Stamp Program on a permanent basis. The Food Stamp Act of 1977, and subsequent amendments, amended the 1964 Act and resulted in the generation of the current Food Stamp Program regulations. The U.S. Department of Agriculture administers the Food Stamp Program nationally through the Food and Nutrition Service (FNS). In Virginia, local departments of social services operate the Program at the county/city level under the supervision of the State Department of Social Services.

The Food Stamp Program started in four Virginia localities (Lee, Wise, Dickenson and the City of Norton) during the pilot phase of its development before the establishment of the permanent program on a national basis. Through requests to operate the Program from local governing bodies, more than 70 localities in the State expanded the Program by June 1974. President Nixon signed the Farm Bill into law in August 1973 that required the nationwide implementation of the Food Stamp Program effective July 1, 1974. Nationwide implementation of the Food Stamp Program eliminated the Surplus Commodity Program, which was an alternate food program available to localities.

C. ISSUANCE SYSTEMS AND FOOD STAMP BENEFIT USE

Eligible households in Virginia receive their food stamp benefits electronically where eligible households receive a plastic EBT card with a magnetic stripe and a personal identification number (PIN) or other access device to access the food stamp benefits.

When households move to areas that do not have EBT issuance of food stamps, the households must receive food coupons to convert the balance of

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their EBT accounts for use in the other area. **Households that move to Puerto Rico must use their food stamp benefits before moving however. These households may not have their unused benefits in the EBT account converted to coupons.**

The local agency must inform eligible households how to access their benefits through EBT and the proper use of the benefits, as described in this chapter.

Upon receipt, the Case Name and authorized representative should each sign their own EBT cards. Eligible households may use the EBT card at any retail store or other food vendor authorized by USDA to accept food stamp benefits. Authorized retailers may display a sign indicating authorization that reads, "We accept Food Coupons" or similar language, or that displays the QUEST logo.

In certain circumstances, eligible households may use food stamp benefits to purchase meals through:

- nonprofit meal delivery services, such as Meals-On-Wheels, or feeding sites for the elderly;
- authorized drug addiction and alcoholic treatment and rehabilitation centers;
- certain group living arrangements;
- shelters for battered women and children; and
- authorized nonprofit establishments that feed homeless persons and restaurants authorized to accept food stamp benefits.

A household may purchase any food or food product for human consumption with food stamp benefits. The household may also purchase seeds and plants for use in gardens to produce food for the personal consumption of the eligible household.

Households may not use food stamp benefits to purchase the following:

- alcoholic beverages or tobacco;
- hot foods ready for immediate consumption;
- pet foods;
- soap products, paper products or other non-food items usually available in a grocery store; or
- foods to be eaten on the store premises.

In addition, household may not use food stamp benefits to pay back grocery bills.

At the certification interview, the Eligibility Worker (EW) should advise the applicant that, when using food stamp benefits, to separate eligible items from ineligible items at the checkout counter unless there is

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2. Denying the Application (7 CFR 273.2(g)(3))

The agency must send a Notice of Action to deny an application if households are ineligible for benefits. The agency must send the denial notice as soon as possible, but not later than 30 days following the application date. Part XXIV contains a copy of the Notice of Action and instructions.

3. Processing Cases with Prior Participation in another Locality

When a household indicates on the application or during the interview that it had been certified in another locality or State, for either the month of application or the prior month, the EW must establish the household's current status with the prior agency. The EW must establish and document the effective date of case closure with the prior agency.

The new locality may not issue duplicate benefits for any months covered by the application if the agency can establish that the household or any of its members are still active in the prior locality.

For household members who are subject to the Work Requirement, the agency must address prior participation in another **Virginia** locality before certifying the members if the agency is aware of such participation. When households move from one Virginia locality to another, the Food Stamp Benefit Tracking Sheet or case information must be shared with the other agency to fully record participation.

Contacts with Other States

For applications filed by persons who certified for food stamp benefits in another state, if otherwise eligible, the Virginia agency must issue benefits if the agency can establish that the household did not participate in the other state. If the agency is not able to establish whether a household or a household member participated in the other State, the agency must accept the household's statement regarding participation. If there is reason to consider a household's statement questionable, the agency must resolve the questionable information before the case is approved. For households entitled to expedited service however, the agency must postpone resolution of this questionable information so that benefit delivery is not delayed beyond expedited processing time.

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The agency must follow-up with the prior agency, after sufficient time for the prior agency to verify if participation occurred in the other state. If duplicate participation occurs for any months in question, the Virginia agency must file a claim for any benefits that the household received while it also received benefits from the other state.

G. DELAYS IN PROCESSING

If the local agency does not determine a household's eligibility and provide an opportunity to participate within 30 days following the date the application was filed, the local agency must take the following action:

1. Determining Cause (7 CFR 273.2(h)(1))

The local agency must determine who caused the delay using the following criteria:

- a. A delay must be considered the fault of the household if the household failed to complete the application process even though the local agency took all required action to assist the household. The local agency is required to take the following actions before a delay can be considered the fault of the household:
 - 1) For households that failed to complete the application, the local agency must have offered, or attempted to offer, assistance in its completion.
 - 2) If one or more members of the household failed to register for work, as required in Part VIII.A, the local agency must have informed the household of the need to register and given the household at least 10 days from the date of notification to register these members.
 - 3) In cases where verification is incomplete, the local agency must have provided the household with a statement of required verification and offered to assist the household in obtaining required verification, and allowed the household sufficient time to provide the missing verification. Sufficient time will be at least 10 days from the date of the local agency's initial request for the particular verification that was missing.

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income if the foster family does not include the foster child in its request for food stamp benefits. If the foster child is included in any other food stamp household, only direct payments from the foster care grant from the foster family to the child or other food stamp household would count as income to that household.

A child in foster care and residing with others may not be considered as a separate food stamp household. Foster children may only participate in the Food Stamp Program as a part of another household in which they live. The restrictions described in this section do not apply to persons assigned to the Independent Living Program.

4. Special Consideration for Elderly and Disabled People (7 CFR 273.1(a)(2)(ii))

Although a group of individuals living together and purchasing and preparing meals together constitutes a single household under the provision of Part VI.A.1.c, an otherwise eligible member of such a household who is 60 years of age or older, (as well as the spouse of such an individual and children under the age of 18 for whom parental control is exercised) who is unable to purchase and prepare meals because he or she suffers from a disability considered permanent under the Social Security Act or suffers from a non-disease-related, severe, permanent disability may be a separate household. However, the gross income of the remaining household members cannot exceed the following amounts (165% of the Federal Poverty Income Guidelines):

<u>Household Size</u>	<u>165% Limit</u>	<u>Household Size</u>	<u>165% Limit</u>
1	\$1,235	6	\$3,394
2	1,667	7	3,826
3	2,099	8	4,257
4	2,530	each additional	
5	2,962	members	+\$432

Do not count the income of the elderly and disabled person and his or her spouse for this calculation. The elderly and disabled person is responsible for obtaining the cooperation of the other individuals in providing necessary income information to the local agency.

The key factor in determining whether or not a disability would qualify a household for separate status under this provision is inability to purchase and prepare meals. In the majority of cases someone with a disability considered permanent under the Social Security Act could be assumed to be incapable of purchasing and preparing meals. However, because disability under the Social Security Act, as well as other disability programs, is based on an inability to work, eligibility workers should not, in every case,

automatically assume the disability constitutes inability to purchase and prepare meals.

No specific verification is required if it is obvious to the EW that the person in question could not purchase and prepare his or her own meals; however, when the inability to purchase and prepare meals is not obvious to the EW, the EW should request that such individuals provide a statement from a physician that they are unable to purchase and prepare their own meals.

5. Residing Together Determinations

In some situations it may become difficult to determine whether persons required to participate together actually reside together. Factors to consider in determining whether persons reside together include, but are not necessarily limited to, the following:

- a. If the persons live in separate, identifiable units, separate households probably exist;
- b. If the persons share common facilities such as a kitchen and/or a bathroom, separate households probably do not exist; and,
- c. If the dwelling is constructed as a single-family home, separate households probably do not exist. If the dwelling is constructed as a multi-family structure (e.g., a duplex, apartment building), separate households exist, in all likelihood.

Examples

- 1) A 20-year-old woman lives in two rooms in her parents' basement. She has a bed, sofa, refrigerator, hotplate, etc., but uses the kitchen and bathroom in her parents' home. All persons must participate together since this is a single-family dwelling and common facilities are shared.
- 2) Individuals live together in the same house. One person lives in an apartment in the basement. The apartment contains a kitchenette and bathroom along with other living space. Since the apartment is a separate, identifiable dwelling unit, the individuals are not considered as living together.
- 3) Individuals live in separate rooms in a hotel, but must share a bathroom down the hall. Since they live in separate, identifiable units, they are not required to participate together even though they share common facilities.

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No. of boarders being considered as a separate household	Minimum monthly payment (This is two-thirds of the maximum coupon allotment, rounded down to the nearest whole dollar amount, for each household size indicated.)
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1	\$ 94
2	172
3	247
4	314
5	373
6	448
7	495
8	566

- 3) A reasonable monthly payment is equal to or will exceed the following amounts if the boarder takes more than two meals per day in the home.

No. of boarders being considered as a separate household	Minimum monthly payment (This is the maximum coupon allotment for each household size indicated.)
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1	\$141
2	259
3	371
4	471
5	560
6	672
7	743
8	849

If a single board payment is made for more than one boarder, all boarders for whom the payment is made are to be considered as a single household.

Example

A mother and daughter are boarding with another household. The mother pays board to the landlord for herself and her daughter. The mother and daughter are to be considered as one household if their board payment is equal to or greater than the required minimum monthly payment.

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In those instances where the individual is furnished meals only (lodging is not furnished), the individual will be considered not as a boarder but as a member of the household where most of his meals are taken.

If questionable, verification of boarder status is to be made by obtaining a signed statement from the boarder and the person to whom the board is paid, attesting to the arrangement and the compensation provided.

C. NONHOUSEHOLD MEMBERS (7 CFR 273.1(b))

1. The following individuals residing with the household will not be considered household members in determining eligibility or the **benefit** allotment.
 - a. Roomers: Individuals to whom a household furnishes lodging, but not meals, for compensation.
 - b. Boarders: Those who meet the boarder definition as given in Part VI.B.
 - c. Live-in attendants: Individuals who reside with a household to provide medical, housekeeping, childcare, or other similar personal services. To "reside with the household" means that the individual takes a majority of his meals in the home. Dependents of a live-in attendant will be considered as members of the live-in attendant's household. A person cannot be a live-in attendant in his own home.
 - d. Ineligible students: Students who are 18 years of age or older and enrolled at least half-time in an institution of higher education who fail to meet the special eligibility criteria set forth in Part VII.E.
 - e. Other individuals who share living quarters with the household but who do not customarily purchase food and prepare meals with the household.

Example

The applicant household shares living quarters with another family to save on rent, but does not purchase and prepare food together with that family. The members of the other family are not members of the applicant's household.

- f. Children in foster care that the household has opted to exclude from the food stamp unit.

received to count as a qualifying quarter. For this provision, public benefits are TANF, SSI, Medicaid and the Food Stamp Programs and the food assistance block grant program in Puerto Rico.

Quarters earned by the spouse of the permanent resident immigrant during the marriage, provided they are still married to each other, may be counted. Quarters earned by parents, including step- or adoptive parents, of a permanent resident immigrant before the alien turns 18, may be counted toward the qualifying minimum for the immigrant, including any quarters earned prior to a child's birth.

- g. Native Americans entitled to cross the border of the United States into Canada or Mexico. This group comprises persons born in Canada to whom INA Section 289 applies or members of an Indian tribe, as defined in Section 4(e) of the Indian Self-Determination and Education Assistance Act.
- h. Highland Laotians and Hmong tribe members who are lawfully residing in the United States and who were part of a Highland Laotian or Hmong tribe between August 5, 1964 and May 7, 1975 when such tribes assisted U.S. personnel. The unmarried dependent children, spouse, and the unremarried surviving spouse of such individuals are also eligible.

Immigrants who originally had refugee, asylum, Amerasian, or Cuban-Haitian designations or who had their deportations withheld (items a-e), but who subsequently gain permanent resident status, must continue to be certified for food stamps under the original designation. Note that after being in the country for five years, these immigrants will be eligible for food stamps indefinitely. See the conditional eligibility section below.

2. Conditional Eligibility of Immigrants

- a. The following categories of immigrants are eligible to participate in the Food Stamp Program provided they also meet a qualified category in subsection b:
 - 1. An individual who has been in the United States as a qualified immigrant for five years or more from the date of entry.
 - 2. Veterans with honorable discharges for reasons not related to alien status and persons who are on active duty in the Armed Forces of the United States, other than training. To be an eligible veteran, one must have served a minimum of 24 months or the period for which the person was called to active duty. The term veteran

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includes military personnel who die during active duty served in the Philippine Commonwealth Army during World War II or as Philippine Scouts following the war.

The spouse or unmarried dependent child of a veteran or person on active duty is also eligible. The surviving spouse of a deceased veteran or of an individual who died while on active duty is also eligible. Eligibility of the surviving spouse is allowed provided the spouse has not remarried and that the marriage was for at least one year, or that they were married before the end of a 15-year period following the end of the period of military service in which the injury or disease was incurred or aggravated; or, that they were married for any period if a child was born of the marriage or was born before the marriage.

3. An individual who receives payments or assistance for blindness or disability, as defined in Definitions.
 4. An individual lawfully residing in the U.S. on August 22, 1996 and who was 65 years of age or older at that time.
 5. A child under 18 years of age lawfully residing in the U.S.
- b. A qualified immigrant is one who is:
1. a lawful permanent resident;
 2. a refugee admitted under INA Section 207;
 3. an asylee admitted under INA Section 208;
 4. one whose deportation is being withheld under INA Section 243(h) or 241(b)(3);
 5. a parolee admitted under INA Section 212(d)(5) and the status is granted for at least one year;
 6. a conditional entrant admitted under INA Section 203 as in effect as of April 1, 1980;
 7. a battered spouse or child, as established by INS and the agencies providing benefits that a substantial connection exists between the battery and the need for benefits;
 8. a Cuban or Haitian entrant; or
 9. an Amerasian immigrant.

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A. INCOME DEDUCTIONS (7 CFR 273.9(d))

Financial eligibility of a household is based on gross or net income as described in Part XI.A. Benefit level is based on net income which is defined as the total of all countable income, both earned and unearned, after the appropriate allowable deductions have been made.

In evaluating expenses toward the calculation of the net income, the household is given credit only for expenses for which a money payment is made or due to someone outside the household. Except for Virginia Energy Assistance Program (fuel assistance) payments, deductions will not be allowed for expenses or the portion of expenses made through vendor payments or for which the household will be reimbursed. Participants of the Low-Income Home Energy Assistance Program (the Virginia Energy Assistance Program) are entitled to have actual utility expenses considered or to have the utility standard applied even if the expenses are covered by fuel assistance vendor payments but utility expenses reimbursed or paid through HUD or FmHA utility reimbursements are not deductible.

All households with income will be allowed the following deductions, if appropriate, in determining net income.

1. Standard Deduction (7 CFR 273.9(d)(1))

Each household is entitled to a standard deduction from the total gross income of the household. The amount of the deduction is dependent on the number of eligible household members. For the purpose of determining the standard deduction, household size will not include disqualified or ineligible members.

Household Size	Standard Deduction
1-4 members	\$134
5 members	\$149
6 or more members	\$171

2. Earned Income Deduction (7 CFR 273.9(d)(2))

Each household with countable earned income may have an earned income deduction. Twenty (20) percent of the countable gross earnings will be deducted.

The earned income deduction is not allowed on any portion of the earned income amount received through a work supplementation or support program that is attributable to public assistance benefits. The deduction is also not allowed when determining an overissuance amount if the basis for the claim is because of the household's failure to report earned income timely.

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3. Dependent Care Expense (7 CFR 273.9(d)(4))

This deductible expense is allowed only if necessary for a household member to accept or continue employment, seek employment, comply with employment and training requirements, or attend training or pursue education that is preparatory for employment. The expense may be incurred for the care of a child or other dependent.

The maximum dependent care deduction is \$200 per month for each child under two years of age and \$175 per month for each other dependent. The total dependent care expense for each dependent should be listed on the worksheet for evaluation but the amount used in the calculation will be limited to the maximum allowed.

Requirements for verification of dependent care expenses are in Parts III.A and E. Forms of acceptable verification include a signed statement from the provider, receipts signed by the provider, or statements from agencies or organizations assisting with child care expenses.

4. Shelter Expense (7 CFR 273.9(d)(5))

The cost of shelter will be considered after all other deductions have been determined. The allowable deduction for shelter may not exceed **\$378**. That portion of the monthly shelter costs that exceeds 50 percent of the household's adjusted net income will be a deduction but, not to exceed **\$378** per month. The adjusted net income is determined by subtracting the standard deduction, earned income deduction, dependent care deduction, child support deduction, homeless shelter standard and medical deduction from the total gross income.

Households that contain a member who is 60 years of age or older, or who is disabled, as defined in Definitions, may receive an excess shelter deduction that exceeds the shelter maximum allowed for other households. These households will receive the actual amount that exceeds half the net income.

The agency must add together all expenses that are part of the cost of shelter, except food, to arrive at a total shelter cost figure. In determining the amount to use as the cost of shelter, the following expenses will count unless vendor payments (Part XI.F.3.) with the exception noted below in item e. cover the expenses. Note the special provisions in section 7 for assessing shelter costs for homeless households.

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- a. Rent, or mortgage or loan payments or other continuing charges leading to ownership of a home, mobile home, or other type of shelter are allowable. This includes second and/or third mortgages and condominium or association fees. It includes the initial cost of moving a mobile home from a dealer to a lot, along with any set-up charges at the lot. For a subsequent move of a mobile home, only the set-up costs at the new lot are allowable. Costs incurred by a tenant in lieu of full or partial rent are allowable rental costs, provided the arrangement is with the mutual agreement of the landlord.
- b. Real estate taxes or personal property taxes on mobile homes are allowable. Taxes on the contents are not allowable.
- c. Insurance premiums on the home structure are allowable. Separate costs for insuring furniture or personal belongings, are not allowable. If insurance premiums on the home structure are combined with other costs that cannot be separated, the total premium is allowable.
- d. Repair costs that result from a fire or flood or a similar disaster are allowable provided the household will not receive reimbursement or assistance from some other source such as insurance, or private or public relief agencies. The disaster does not have to be a presidential declaration but can be personal, such as a fire damaging only one home.
- e. Utilities incurred separately and apart from the rent or mortgage cost are allowable. Actual direct utility costs may be used in determining shelter costs, even if the Virginia Energy Assistance Program covers the costs by a vendor payment.

In some situations the household may be entitled to use the utility standard as its utility expense, rather than its actual utility expenses.

A standard utility allowance has been established based on the number of persons in the residence. The standard includes an allowance for heat, electricity, gas, water, sewerage, septic tank maintenance fees, garbage collection and telephone. A household may use the standard utility allowance only if the household is responsible for a heating or cooling expense, or it receives Low Income Home Energy Assistance Program benefits.

Number of Persons	Utility Standard
1 - 3	\$206
4 or more	\$253

Multiple family units living in the same residence may have only one standard utility allowance for the residence, based on the total number of people in the residence. The agency must divide the one utility standard among the units that contribute to meeting heating or cooling costs, whether or not each unit participates in the Food Stamp Program. In these instances, each unit may use only its prorated share of the standard allowance, unless it uses its actual costs. The agency may not prorate the standard allowance if the nonhousehold members are all excluded from the household because they are ineligible to participate in the Food Stamp Program.

Example

A three-person food stamp unit lives in a house with another person. The food stamp unit and the other person each pay half of the heating costs. The food stamp unit's standard utility allowance is **\$126.50**, i.e. **\$253** (based on total number of persons in the home being 4 or more) divided by 2 (the number of units contributing to heating costs). The food stamp unit may opt to use **\$126.50** as its utility costs, or may use its actual utility expenses.

Only those households that receive Low Income Home Energy Assistance payments or that are responsible for an identifiable heating or cooling expense or an established percentage of an identifiable expense have the option of the utility standard. A cooling cost is a verifiable utility expense relating to the operation of air conditioning systems or room air conditioners. A heating cost is a verifiable utility expense for a primary fuel source.

Examples

- 1) The food stamp client pays for electricity that the household needs to operate the oil furnace. Other persons in the home buy oil. The food stamp client is not entitled to the standard since he has no expense for the primary fuel source. The actual electric bill is allowable since this is a direct utility expense.
- 2) A food stamp client cuts his own wood. This wood is free, but he incurs expenses of gas and oil for his chain saw. The household may not use the standard since the household does not incur an expense for the primary fuel source. The actual incidental expenses connected with obtaining the wood are not allowable since these are not direct utility expenses.

If a household incurs a utility expense such as electricity or gas that includes heating or cooling along with other uses, e.g., cooking or light, the utility standard may still be used. If the household does not incur a separate expense for heating or cooling, it is not entitled to the utility standard unless it receives Low Income Home Energy Assistance payments. Actual costs of utilities incurred by households not entitled to the utility standard are allowable expenses.

Households that have their utilities included in their rent, but who may, on occasion, have to pay an excess utility charge are not be allowed the use of the utility standard unless they receive Low Income Home Energy Assistance Payments. Households that receive HUD or FmHA payments may use the utility standard if they are responsible for utility costs beyond the HUD or FmHA payment. Households that pay a flat amount, not a percentage, for utilities to the homeowner instead of the utility vendor may not use the utility allowance. Actual or anticipated amounts for these utility charges are allowable.

If a household incurs a heating or cooling expense at any point during the year, or if such an expense is anticipated, or the household received a Low Income Home Energy Assistance payment during the period of time covered by the utility standard, or such a payment is anticipated, the utility standard may be used by the household for the full year.

Examples

- 1) A household buys oil twice a year in November and February to heat the home. This household is entitled to use the utility standard for the full twelve months of the year.
- 2) A household lives in an apartment where heat is included in the rent. The household, however, uses an air conditioner in the summer and is responsible for the electric bill for the apartment. Since a cooling expense is incurred, the household is entitled to use the utility standard for the full twelve months of the year.

Each household must receive a thorough explanation of the options available in considering utility expenses. The household may switch between use of the standard and actual costs only at the time of certification. If the household moves while certified, the household may switch from one to the other. If the household initially chose to use actual utility costs but the utility standard was allowed because the

household failed to verify the costs timely, the use of actual costs upon receipt of verification will not be allowed until recertification.

- f. The utility standard includes the basic service fee for a telephone so a household that uses the utility standard may not also claim a separate telephone expense. For a household that uses actual utility expenses and who incurs an expense for a basic telephone service, or an established percentage of such an expense, the household must use a telephone standard of **\$51**, or the appropriate percentage of the standard.

The agency must divide the telephone standard among households sharing the expense. A telephone expense is allowable even if the household is not entitled to any other utility allowance.

Example

Two food stamp units live together and each pays half of the telephone bill. The bill includes charges for basic service. Each household will receive half the telephone standard as its telephone expense.

- g. Initial installation fees charged by a telephone, utility, or septic tank company are allowed as an expense, over and above the cost of the actual utility. Initial installation fees are allowable even if the utility or phone standards are used. The household may choose to have the installation bill averaged over the months in the certification period or to have the bill assigned to the month received or due. If a payment or budget plan has been established, the expense may be allowed for each month in the payment plan.
- h. One-time deposits for utilities, telephones, apartments, etc., will not count as shelter costs.
- i. Shelter expenses, as described above, include the costs for a home (owned or rented) that is temporarily unoccupied provided the household intends to return to the home. The home may be unoccupied because of employment, training, illness, or a natural disaster or loss. If the household has shelter expenses for both an occupied and unoccupied home, the household is entitled to only one utility or telephone standard.

The cost of shelter cannot be claimed if the vacated home is rented to someone else or if a rent-free occupant is claiming the cost of shelter for the home in question for food stamp purposes.

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A. INCOME ELIGIBILITY STANDARDS (7 CFR 273.9(a))

To be eligible for Food Stamp benefits, the countable gross monthly income of households shall not exceed the monthly income limits shown below in Chart #1. The gross income limits of Chart #1 do not apply to households with a member who is 60 years of age or over (including a member whose 60th birthday is in the month of application), or to households with a member who is disabled, as defined in Definitions.

For the self-employed, the EW must first exclude the cost of doing business. For the student receiving educational benefits, the EW must first exclude allowable educational expenses as described in Part XII.G.

All households, except those that are categorically eligible, must be determined eligible based only on net income (gross income less allowable deductions listed in Part X.A). The maximum net income limits are shown in Chart #2.

INCOME ELIGIBILITY LIMITS		
Household Size	CHART #1	CHART #2
	Gross Income Maximum	Net Income Maximum
1	\$ 973	\$ 749
2	1,313	1,010
3	1,654	1,272
4	1,994	1,534
5	2,334	1,795
6	2,674	2,057
7	3,014	2,319
8	3,354	2,580
Each additional member	+341	+262

Net income is the basis for the allotment for all households. While categorically eligible households, as defined in Part II.H.3, do not have to meet either the gross or net income eligibility standards, the net income limits are used to determine entitlement to an allotment even for these households.

B. COUNTABLE INCOME

Countable income is all household income, earned and unearned, from whatever source, excluding only that income specified in Part XI.F.

Income received by one person for another person or for multiple beneficiaries is considered the income of the person receiving it, unless the provisions of Part XI.G. (earned income of several members combined into one payment) are applicable. Evaluate any income exclusions, such as third party fund exclusion, according to Part XI.F.

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When verification of income is required, the local agency must verify gross amounts, and the rate and frequency (i.e., weekly, semi-monthly, etc.) of the income the employee receives. For income received more often than monthly, verify the payment cycle, i.e., the day the employee receives the income.

C. EARNED INCOME (7 CFR 273.9(b)(1))

Earned income includes:

1. Wages and Salaries

All wages and salaries for services performed as an employee. This includes wages held by an employer at the employee's request and advances on wages as discussed in Part XII.G. Gross wages are considered, regardless of the amount and nature of the deductions, unless any portion of the gross pay is considered excludable under Part XI.F. or unless the gross amount reflects credit for employee benefits. In situations where benefits are reflected as credits and where the employee cannot elect to receive a cash payment, the amounts shown on the pay stub will not count as income. If an employee elects to have money withheld from the earnings to pay for employee benefits, that money must be counted as income.

If the employer still considers the individual as an employee, consider vacation pay and sick pay as earned income. Additionally, for sick pay, the employer must make the payment directly in order to consider the money as earned income; otherwise, it is unearned income.

If the individual has terminated employment, accumulated vacation pay and sick pay are considered earned income if received in more than one installment, and a lump sum resource if received in one installment. Laid-off employees are terminated employees for the purposes of this policy. If a laid-off employee opts not to withdraw vacation and/or sick pay, the value of such funds counts an available resource.

Consider bonus pay as earned income.

Consider severance pay as unearned income.

2. Self-Employment Income

The gross income from a self-employment enterprise including the total gain from the sale of any capital goods or equipment related to the business, excluding the cost of doing business. (See Part XII.A.)

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Sale price	\$1,000
Reported as gross	<u>x 50%</u>
Taxable income	\$ 500

For Food Stamp purposes the entire proceeds, or \$1,000, would be included as gross income.

5. Allowable Costs of Producing Self-Employment Income (7 CFR 271.11(a)(4))

Allowable costs of producing self-employment income include, but are not limited to, the following:

- a. the identifiable costs of labor, stock, raw material, seed and fertilizer.
- b. payments on the principal of the purchase price of income producing real estate and capital assets, equipment, machinery and other durable goods or on the principal for improvements to real estate.
- c. interest paid to purchase income producing property, capital assets, equipment, machinery, and other durable goods.
- d. insurance premiums paid on income producing property.
- e. taxes paid on income producing property.
- f. costs of repairs to property needed for general maintenance.
- g. identifiable shelter costs needed for the business enterprise.

For households whose mortgage payments represent an investment in the household's residence as well as an investment in income producing property, the mortgage payment, interest, and taxes will be deductible only as part of the household's shelter costs and not as a cost of producing income. If the household can document, however, that costs on that portion of the home used in the self-employment enterprise are separate and identifiable, payments on the mortgage principal, taxes, interest, and other identifiable costs may be deducted as a cost of doing business.

6. Costs Not Allowed (7 CFR 273.11(a)(4)(ii))

The following items are not deductible as a cost of doing business:

- a. net losses from previous periods.
- b. federal, state, and local income taxes.

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- c. money set aside for retirement purposes.
- d. other work related personal expenses, such as transportation to and from work.
- e. depreciation.

NOTE: "b", "c", and "d" are included in the 20% earned income deduction.

7. Allowable Costs of Producing Income for Day Care Providers

When day care is provided in the home of a member of one household to children other than those living in the same food stamp household, an allowance must be made for the cost of meals and snacks that are provided. The allowance is as follows, unless the provider documents actual costs that exceed these amounts:

Breakfast - **\$.99** per meal; Lunch or Supper - **\$1.83** per meal;
Snacks - **\$.54** per meal.

Money paid to day care providers under Section 12 of the School Lunch Act to serve meals to children, other than their own, is countable. Allowable business costs, as described above, are given.

8. Net Loss from Farm or Fishing Operations (7 CFR 273.11(a)(2)(iii))

Self-employed farmers, as defined in Part XII.A.b, and self-employed fishermen may have a net loss once allowable costs of doing business are deducted from gross farm income. If the farmer or fisherman receives annual gross proceeds of \$1,000 or more from the farming or fishing enterprise, any net loss amount must be prorated over the year in the same manner used to prorate the farm or fishing income. Losses from farm or fishing self-employment enterprises are offset in two phases. The first phase is offsetting against non-farm/fishing self-employment income. The second phase is offsetting against the total of earned and unearned income. The gross income eligibility standard is applied after offsetting. The earned income deduction is based on wages and salaries, and any income from self-employment remaining after the first phase of offsetting.

9. Depreciation

Depreciation is not allowed as a cost of producing self-employment income for equipment, machinery or other capital investments necessary to the self-employment enterprise.

B. BOARDERS (7 CFR 273.11(b))

The income of households owning and operating a commercial boarding house is handled as self-employment income under Part XII.A.2 and 3. A commercial boarding house is an establishment licensed as a commercial enterprise that offers meals and lodging for compensation. In localities without licensing requirements, a boarding house is as a commercial establishment that offers meals and lodging for compensation with the intent of making a profit. The number of boarders residing in a boarding house is not used to determine if a boarding house is a commercial enterprise.

For all other households containing boarders, the income from the boarders must be calculated following the procedures in this chapter. See Part VI.B. to determine boarder status.

1. Income from the Boarder

The income from boarders must include all direct payments to the household for room and meals, including payments to the household for part of the shelter expenses. Shelter expenses paid by boarders directly to someone outside the household (such as a landlord or utility company) are not counted as income to the household.

2. Cost of Doing Business

To determine the net amount of countable income from a boarder the EW must deduct the cost of doing business from the gross monthly income figure.

The cost of doing business is equal to one of the following:

- a. If the household takes more than two meals per day, the amount of the maximum coupon allotment for a household size that is equal to the number of boarders; or,
- b. if the household takes two meals or less per day, the amount equal to two-thirds of the maximum coupon allotment for a household size that is equal to the number of boarders; or,
- c. the actual documented costs of providing room and meals, if they are higher than the appropriate coupon allotment.

The allowable cost of doing business may never exceed the amount the household receives from the boarder. If actual costs are used, only separate and identifiable costs of providing rooms and meals to the boarders are allowed.

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3. Earned Income Deduction

The 20% earned income deduction as defined in Part X.A.2. will be allowed for all income from boarders. The net boarder payment must be added to all other earned income before allowing the 20% deduction.

C. SPONSORED IMMIGRANTS (7 CFR 273.4(c))

Affected Groups

All immigrants granted U.S. visas based on family connections and some employment-based immigrants must have a sponsor in order to obtain permanent residency. The sponsor must execute an affidavit of support on behalf of the immigrant to demonstrate financial responsibility for the immigrant.

This chapter applies to persons who file visa applications on or after December 19, 1997, and for persons who file for an adjustment of status on or after December 19, 1997.

Individual sponsors must document that they have the capacity to financially support and maintain an immigrant, generally at 125 percent of the federal poverty level. The sponsor must execute a legally enforceable affidavit of support, INS Form 864, on behalf of each immigrant. The sponsorship affidavit also requires an agreement to reimburse agencies for any means-tested public benefits obtained by the sponsored immigrant.

The agency must evaluate the provisions of this chapter for immigrants who are eligible for food stamps as permanent resident immigrants with 40 quarters of work credited to them (Part VII.F.1.f.) and for permanent residents who are conditionally eligible for food stamps if they meet a qualified status (Part VII.F.2.).

Exemptions

The provisions of this chapter do not apply to the following groups:

- Immigrants without sponsors. This group includes persons who entered the United States without an individual sponsor who signed a legally binding affidavit of support. These immigrants include refugees, asylees, persons whose deportation is withheld, Amerasians and Cuban/Haitian entrants.
- Immigrants whose sponsors signed affidavits of support before December 19, 1997 or persons whose sponsors have not signed a legally enforceable affidavit of support.
- **Immigrant children under 18 years of age.**

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January, the employee reports that his salary was increased to \$4800 per year. Now, \$400 is assigned to the months remaining in the contract period. (\$4800 divided by 12 equals \$400.)

3. Termination of Annualized Income

If no further income from the same source is expected, contract income that has been annualized is considered terminated as of the last month included in the annualization.

Example

A contract school employee is paid \$6,000 over the ten months in the school year, September through June. She grosses \$600 in each of the 10 months. She does not plan to work for the school board in the next school year.

The Food Stamp worker annualizes the income over the year September through August, and counts $\$6,000 \div 12 = \500 per month.

Should the employee apply in June, her income is not considered terminated in June, even though June is the last month she receives a pay check. The income is terminated in August, the last month included in the annualization.

Income that is interrupted within the contract period is considered terminated the month the change in contract employee status occurs.

Example

A school employee quits in February. The agency annualized her contract income and assigned income to the months September through August. The income will no longer count for February

Self-employment income that has been annualized is considered terminated as of the month the person terminates the self-employment enterprise.

G. WAGES HELD BY AN EMPLOYER

Wages held by an employer at the request of the employee will count as income to the household for the month the wages would otherwise have been paid by the employer. Wages held by the employer as a general practice

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will not count as income to the household even if it is in violation of law. Held wages will count if the household expects to ask for and receive an advance, or expects to receive income from wages that the employer previously held as a general practice. This income will count as long as the local agency did not previously count the income.

Advances on wages count as income in the month received only if the EW can reasonably anticipate the receipt of the income as defined in Part XIII.A.3. Conversely, when an employer withholds wages to repay an advance that previously counted as income in a food stamp determination, the wages withheld will not count as income.

H. TRANSITIONAL BENEFITS FOR FORMER TANF RECIPIENTS

Transitional Benefits allow food stamp benefits to continue in a frozen amount for a brief period while former TANF recipients adjust financially to the loss of the TANF grant. At any time during the Transitional Benefits period, the household could decide to reapply and receive a regular food stamp allotment.

1. Transitional Benefits Eligibility

When a TANF case closes, the EW must convert the food stamp case to Transitional Benefits unless the food stamp household is ineligible for Transitional Benefits or the household requests closure of the food stamp case.

Transitional Benefits will apply to any food stamp case:

- if at least one household member is the Case Name or Payee for a TANF case that closed and
- with a closed TANF case.

Transitional Benefits will not apply if:

- the TANF case has a suspended status, regardless of the reason for the suspension;
- the TANF case closed because of noncompliance with TANF Program rules that results in a sanction or disqualification of the TANF benefits;
- **the household requests to remain in the regular Food Stamp Program before the switch to Transitional Benefits occurs.**

A. DETERMINING HOUSEHOLD ELIGIBILITY AND BENEFIT LEVELS (7 CFR 273.10(a))

Eligibility and level of benefits for those submitting an initial application, reapplication or recertification must be based on circumstances reasonably anticipated for the months of eligibility.

Applicant households consisting of residents of a public institution who apply jointly for SSI and food stamps prior to release from the institution will have their eligibility determined for the month in which the applicant was released from the institution.

Because of anticipated changes, a household may be eligible for the month of application, but ineligible in the subsequent month. The household is entitled to benefits for the month of application even if the processing of its application results in the benefits being issued in a subsequent month. Similarly, a household may be ineligible for the month of application, but eligible in a subsequent month due to anticipated changes in circumstances. Even though denied for the month of application, the household does not have to reapply in the subsequent month. [The same application must be used for the denial for the month of application and the determination of eligibility for subsequent months, within the timeliness standards in Part II.F.]

As a result of anticipating changes, the household's allotment for the month of application may differ from its allotment in subsequent months. The local agency must establish a certification period for the longest possible period, as allowed by Part IV.A.2. over which changes in the household's circumstances can be reasonably determined. The household's allotment can vary month to month within the certification period to reflect changes determined at the time of certification. Benefits for the initial month or a subsequent month must be prorated from the day of application, the day the household provides the last verification or takes the final action, or the day the household establishes eligibility in accordance with Part XIII.D.

1. Household Composition

A household's membership for eligibility determination and benefit level is assessed as of the application date for the month of application or the first day of the month following entry or attachment to the household for ongoing eligibility. Refer to Part VI of this manual for guidelines in determining household composition.

If any household member is included in another active food stamp case for the month of application, reapplication or recertification, eligibility for the remaining household members must be determined. The household member included in another case is added to the current case as soon as administratively possible.

The EW must add the individual to the gaining household for the earliest possible month after the move. However, if the person cannot be removed from the old household effective the following month, the person cannot be added to the new household until the person is deleted from the old one. For example, a member moves on June 28 and there is insufficient time to send advance notice effective July 1, so the deletion is effective August 1. A new member cannot be added to the household until the individual's income and resources have been determined and eligibility determined.

If the individual's move coincides with the gaining household's recertification, the new member is added in the same timeframes as though the change occurred during the certification period. The new member is added for the earliest possible month, and depending on the dates involved, the recertification may be processed without the new member being immediately included.

NOTE: Participation in more than one household in a month is prohibited, with the exception noted in Part VII for people who leave a household containing a person who abused them and enter a shelter for battered women and children.

When a household reports the loss of a member, the individual is deleted as soon as administratively possible. The EW has a maximum of 10 days to act on the change. A 10-day advance notice period must be provided if the deletion results in negative action.

When an individual is deleted from a household, the income and deductible expenses of the person must be deleted effective the same month, unless the provisions for considering income and expenses of ineligible or disqualified members are applicable.

2. Special Circumstances (FNS Waiver 930085)

If a household member is turning 60, the net-income-only eligibility test, allowance of medical deductions and removal of the shelter maximum are given for the month the member turns 60. If a household member will turn 60 during a certification period, it is the agency's responsibility to act on any reported medical expenses on file and remove the shelter maximum for the month the person turns 60.

If a household member is turning 18 and has previously excluded earnings, that earned income is countable and must be evaluated for the month following the month in which the member turned 18. When an application is filed indicating that a child has earnings which are excluded, it is the agency's responsibility to make timely adjustments for the month following the month in which the child turns 18.

In addition to counting income for a person turning 18, the agency may need to reevaluate the immigration status of such a person.

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A. CHANGES DURING THE CERTIFICATION PERIOD

When changes occur within the certification period that affect the household's eligibility or the amount of the benefit allotment, the agency must act to adjust the household's benefit level. The responsibility for changes lies with both the recipient household and the local agency. The household must report certain changes in income and household status; the local agency must act to make adjustments in entitlement and benefit level based on reported changes and for changes the agency initiates. Unless prohibited, certified households must file an Interim Report about their circumstances during the certification period.

1. Changes that Must Be Reported

Certified households must report the following changes in their circumstances:

- a. A new physical or mailing address.
- b. When the total income exceeds the gross income limit based on household size at the time of certification, the Interim Report evaluation, **or a change reported during the certification period.** The income limits are:

Household Size	<u>Income Limits</u>			
	Monthly Amount	Weekly Amount	Bi-Weekly Amount	Semi-monthly Amount
1	\$ 973	\$226.28	\$ 452.56	\$ 486.50
2	1,313	305.35	610.70	656.00
3	1,654	384.65	769.30	827.00
4	1,994	463.73	927.45	997.00
5	2,334	542.80	1,085.59	1,167.00
6	2,674	621.87	1,243.73	1,337.00
7	3,014	700.94	1,401.87	1,507.00
8	3,354	780.00	1,560.00	1,677.00
Additional members	+ \$341	+ \$79.31	+ \$158.61	+ \$170.50

- c. Persons exempt from time-limited benefits of the Work Requirement because they are working for an average of 20 hours per week must report when their work hours fall below 20 hours weekly.

Households that receive benefits through the Transitional Benefits component for former TANF recipients do not have to report changes except changes in their address.

Households must report the changes listed above within 10 calendar days from the date the household knows of the change or, at the

latest, 10 days into the next month after the month the change occurs. The 10-day reporting period will begin the day the household knows of the change. If the household is uncertain of the exact date or amount of the change, then the 10-day reporting period will begin the day the change occurs.

The household may report a change on the Change Report Form, by telephone, by personal contact, by mail, or electronically. The household may also report a change of its circumstances with the filing of the Interim Report. A household member, an authorized representative, or any person having knowledge of the household's circumstances may report the change to any staff member of the local agency. When the household reports the change by mail, the report will be timely as long as the postmark of the letter is within the required 10-day period regardless of when the local agency receives the information.

During the interview, the EW must advise an applicant of the responsibility to report changes within the required period and of the changes the household must report. The EW must provide the household the telephone number of the food stamp office and, if necessary, a toll-free number or a number for accepting collect calls from households outside the local calling area.

The local agency must provide the Change Report Form to each household at initial application and reapplication. Additionally, the local agency must provide the form at recertification, if the household needs another form, and whenever the household returns a form. The EW must discuss use of the form with the household during the interview.

An applying household must report changes related to its Food Stamp eligibility and benefits at the certification interview. The household must report the changes noted at the beginning of this chapter that occur after the interview but before the date of the Notice of Action to approve the case within 10 days of the date of the approval notice.

2. Local Agency Action on Changes (7 CFR 273.12(c), 273.2(f))

The agency must act promptly to terminate or to adjust benefits when changes in household circumstances or income reported by recipient households or otherwise become known to the agency, including changes initiated by the agency. While the household is required to report only the elements listed at the beginning of this chapter, the agency must act on all information received to adjust food stamp benefit level or eligibility unless the household receives benefits through the Transitional Benefits component for former TANF recipients. For Transitional Benefits cases, the EW must input changed information in

ADAPT during the Transitional Benefits period but then grant benefits in the frozen amount calculated when the TANF case closed by using the override feature of ADAPT. See Part XII.H.

The Appendix to this chapter contains charts that outline the procedures for handling changes reported or discovered during the certification period.

The agency has 10 days from the date the agency learns of the change to act on the change. When the reported change requires a reduction, termination or suspension of benefits, the EW must issue an advance notice within 10 calendar days, beginning with the date the agency receives the change, unless one of the exemptions for mailing the notice in Part XIV.B is applicable. In these cases, depending on the change, the agency must send an adequate notice if a notice is required at all.

Part III.F contains required agency actions needed in response to information obtained through IEVS. The household or the source of information must verify unverified information received through IEVS. If the agency opts to obtain verification from the household, the agency must request the information in writing and allow the household 10 days to respond. The agency must send an advance notice to terminate the case if the household fails to respond timely.

If the household reports the addition of a new member, that person may not be included in the allotment until the agency knows the income and resource information about the individual.

Required Supplemental Allotments

If the reported change requires an increase in the household's benefits, the change must be reflected no later than the first allotment issued ten (10) days after the date the change was reported. However, if the increase in benefits is a result of the addition of a new household member, or is the result of a decrease of \$50 or more in the household's gross monthly income, the agency must reflect the change no later than the month following the month in which the change was reported. If it is too late in the month to adjust the upcoming month's allotment, it will be necessary to issue a supplementary allotment by the 10th of the upcoming month.

The allotment for a household assigned to a subsidized work placement for TANF will remain at the amount authorized for the household for the month immediately preceding the placement in the subsidized work component. A supplement must be issued if the employment services worker determines that good cause exists if the amount of wages earned is less than the amount of the combined TANF and food stamp benefits. In addition, when changes occur which result in an

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allotment increase of at least \$25, the EW must review the case to see if net wages from the subsidized job and any advance tax credit payments continue to equal or exceed the combined amount of benefits from TANF and food stamps. The household must receive a supplement if the TANF and food stamp benefit amounts exceed the amount of net wages.

Voluntary Supplemental Allotments

At its option, the local agency may give supplemental for individual household changes in the month of the changes. The agency may not give supplemental allotments for household composition changes. The agency may give supplemental allotments for income reductions or increased shelter, medical or dependent care expenses.

If the agency opts to provide supplements, the agency must give the supplements for all similar situations, e.g., medical expenses more than \$100, loss of income or income reductions of \$200 or more, etc.

Changes and Verification

When a change will increase benefits, the agency must require verifications before the issuance of the second normal monthly allotment reflecting the change. If the household does not provide verification, the household's benefits will revert to the original benefit level. If there is a refusal to cooperate documented, the agency must close the case with an advance notice. The agency does not have to issue an advance notice if benefits revert to the original level because of the lack of verification if the previous notice so advised the household at the time of the increase.

Whenever a change will decrease benefits, the agency must obtain required verifications before recertification **or for the Interim Report**. The agency must also obtain required verification before recertification **or, depending on the changed element, for the Interim Report** when a change neither increases nor decreases benefits.

The agency must request and obtain verification for earned income changes. The agency must verify changes in unearned income, voluntarily reported medical expenses and actual utility expenses if the source changed or, the amount changed by more than \$25 since the last verification.

If the EW learns of a change in medical expenses, from a source other than the household, the EW must act on the change if the expense is verified upon receipt and if the EW can make the change without additional information or verification from the household. If action on the change requires additional information from the household, the EW may make the change during the certification period.

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A. GENERAL PROVISIONS

All persons who are able to work must be working or actively engaged in a work activity in order to receive food stamps. Unless an exemption to the Work Requirement exists, individuals may receive food stamps for only three months during a 36-month period. After the initial three-month period (Y1 benefits), an individual may receive benefits through a Special Exemption (E9) to allow certification up to six months. Special Exemption E9 months may also extend the certification period to six months for households with members who regain eligibility. **The E9 code does not apply when a member's exemption status changes during an established certification period.**

A nonexempt able-bodied household member must:

1. work for cash wages in any amount or for in-kind goods or services for 20 hours or more per week, averaged monthly;
2. participate in and comply with requirements of an employment services program operated by the Department of Social Services, other than job search, for 20 hours or more per week or for the number of hours assigned for the work experience component as calculated by the household's allotment divided by the federal minimum wage;
3. participate in and comply with non-departmental (DSS) work programs for 20 hours or more per week;
4. serve in an unpaid, volunteer capacity for a public or private agency, at a minimum, for the number of hours that is equal to the household's allotment divided by the federal minimum wage; or
5. any combination of these activities

in order to receive food stamps beyond three months. A nonexempt able-bodied household member may also participate in and comply with Workfare program requirements (Part XXII) in order to receive food stamps beyond three months. If the member was unable to work, as described above, because of good cause, the member will meet the Work Requirement as long as the absence is temporary and the member retains the job.

The 36-month period is a fixed period from the first of the month in which a household containing an individual subject to the Work Requirement is certified **in Virginia**. The 36-month period will begin and continue for any household member between the ages of 18 and 50, even if an exemption from the work requirement exists for that member at the time of certification or other case action. Tracking must be completed for all persons within the age range, even when they are exempt.

Any month in which an affected individual receives the full benefit month as part of a certified household will count toward the three-month limit.

Months in which a household receives prorated benefits will not count toward the three-month limit. Months in which the household does not receive an allotment because benefits are prorated to zero (i.e., less than \$10) will not count toward the limit however. Months in which a certified household is eligible to receive benefits but does not actually participate do not count toward the three-month period. Months for which a household repays benefits received erroneously also will not count toward the three-month limit once the household repays the claim in full.

A work program, for the purposes of this provision, will include programs operated under the Workforce Investment Act (WIA) and the Trade Adjustment Assistance Act in addition to the agency-sponsored employment and training programs. Job search activities assigned through FSET or other state or local social services programs are not acceptable tasks to count toward establishing a household member's eligibility for continuing benefits beyond the initial three-month limit. Job search activities assigned through WIA will be evaluated as an acceptable task however.

After three months of receiving benefits and a varying of E9 months, an individual, not exempt from the Work Requirement, is not entitled to additional benefits during the balance of the 36-month period, except as allowed in Part XV.C. The agency must send an advance notice to participating households when a member becomes ineligible to participate further. These household members are disqualified household members during any period in which the individuals do not meet the Work Requirement. See Parts VI.C and XII.E for a discussion of disqualified household members.

Ongoing households with members who are not eligible because of the work requirement must continue to report changes involving these members.

B. WORK REQUIREMENT EXEMPTIONS

The following persons are exempt from the Work Requirement:

1. Any person who is under 18 years of age or over 50 years of age. See Part XIII.A.2.
2. Any person who is medically certified as mentally or physically unfit for work.
3. Any adult member of a food stamp household of which a child under age 18 is present.
4. A pregnant woman.
5. Any resident of an exempt locality. The exemption may be based on the unemployment rate of the locality or its identification as a Labor Surplus Area.

VIRGINIA LEGAL AID PROJECTS

<u>Name and Address</u>	<u>Areas Served</u>
Blue Ridge Legal Services, Inc. 204 North High Street Harrisonburg VA 22801 (540)433-1830 1-800-237-0141	Augusta County Harrisonburg Highland County Page County Rockingham County Southern Shenandoah Staunton Waynesboro
Blue Ridge Legal Services, Inc. P.O. Box 436 119 South Kent Street Winchester VA 22601 (540)662-5021 1-800-678-5021	Clarke County Frederick County Northern Shenandoah County Warren County Winchester
Blue Ridge Legal Services, Inc. 203 North Main Street Lexington VA 24450 (540)463-7334 (540)862-7642: Covington, Clifton Forge, Alleghany	Alleghany County Bath County Buena Vista Clifton Forge Covington Lexington Rockbridge County
Blue Ridge Legal Services, Inc. 132 Campbell Avenue, SW Suite 300 Roanoke VA 24016 540-344-2088 1-866-534-5243	Bedford Bedford County Botetourt County Craig County Franklin County Roanoke Roanoke County Salem
Central Virginia Legal Aid Society 101 West Broad Street, Suite 101 Richmond VA 23220 P.O. Box 12006 Richmond, VA 23241 804-648-1012 1-800-868-1012	Charles City County Chesterfield County Goochland County Hanover County Henrico County New Kent County Powhatan County Richmond City

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<u>Name and Address</u>	<u>Areas Served</u>
Central Virginia Legal Aid Society 617 W. Main Street, 2 nd Floor Charlottesville VA 22903 (434) 296-8851 1-800-390-9983	Albemarle County Charlottesville Fluvanna County Greene County Louisa County Nelson County
Central Virginia Legal Aid Society 10-A Bollingbrook Petersburg VA 23803 804-862-1100	Charles City County Colonial Heights Dinwiddie County Hopewell Petersburg Prince George County Surry County
Eastern Virginia Legal Aid Society 125 St. Paul's Boulevard Norfolk VA 23510 757-627-5423 1-800-868-1072	Chesapeake Norfolk Portsmouth Virginia Beach
Legal Aid Justice Center 1000 Preston Avenue, Suite A Charlottesville VA 22903 (434) 977-0553 1-800-578-8111	Albemarle Charlottesville Fluvanna Greene Louisa Nelson
Legal Aid Society of Roanoke Valley 416 Campbell Avenue SW Roanoke VA 24016 (540) 344-2088 1-800-711-0617	Bedford Bedford County Botetourt County Craig County Franklin County Roanoke Roanoke County Salem
Legal Services of Eastern Virginia 2017 Cunningham Dr. Suite 300 Hampton VA 23666 757-827-2912 1-800-944-6624	Chesapeake Hampton Newport News Norfolk Portsmouth Virginia Beach

<u>Name and Address</u>	<u>Areas Served</u>
Legal Services of Eastern Virginia 199 Armistead Avenue Williamsburg VA 23185 757-220-6837 1-800-455-8208	Gloucester County James City County Mathews County Middlesex County Poquoson Williamsburg York County
Legal Services of Eastern Virginia 36314 Lankford Highway, Suite 5 P.O. Box 306 Belle Haven VA 23306 757-442-3014 1-800-455-8208	Accomack County Northampton County
Legal Services of Northern Virginia 6400 Arlington Boulevard Suite 630 Falls Church VA 22042 703-532-3733	Alexandria Arlington County Fairfax County
Legal Services of Northern Virginia 603 King Street, 4 th Floor Alexandria VA 22314 703-684-5566	Alexandria
Legal Services of Northern Virginia 1916 Wilson Boulevard, Suite 200 Arlington VA 22201 (703) 532-3733	Arlington County Falls Church
Legal Services of Northern Virginia 4080 Chain Bridge Road Fairfax VA 22030 703-246-4500	Fairfax Fairfax County
Legal Services of Northern Virginia 204 Wirt Street, SW Leesburg VA 20175 703-777-7450	Loudoun County
Legal Services of Northern Virginia 9240 Center Street Manassas VA 20110 703-368-5711	Manassas Manassas Park Prince William County

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<u>Name and Address</u>	<u>Areas Served</u>
Rappahannock Legal Services, Inc. 910 Princess Anne Street Fredericksburg VA 22401 540-371-1105	Caroline County Fredericksburg King George County Spotsylvania County Stafford County
Rappahannock Legal Services, Inc. 314 North West Street Culpeper VA 22701 540-825-3131	Culpeper County Fauquier County Madison County Orange County Rappahannock County
Rappahannock Legal Services, Inc. P.O. Box 1662 Tappahannock VA 22560 (804) 443-9393 1-800-572-3094	Essex County King & Queen County King William County Lancaster County Northumberland County Richmond County Westmoreland County
Southwest Virginia Legal Aid Society, Inc. 155 Arrowhead Trail Christiansburg VA 24073 540-382-6157 1-800-468-1366	Floyd County Giles County Montgomery County Pulaski County Radford
Southwest Virginia Legal Aid Society, Inc. 227 West Cherry Street Marion VA 24354 (276) 783-8300 1-800-277-6754	Bland County Bristol Carroll County Galax Grayson County Smyth County Washington County Wythe County
Southwest Virginia Legal Aid Society, Inc. P.O. Box 670 Castlewood VA 24224 (276) 762-9356 1-888-201-2772	Buchanan County Dickenson County Lee County Norton Russell County Scott County Tazewell County Wise County

<u>Name and Address</u>	<u>Areas Served</u>
Virginia Legal Aid Society 513 Church Street Lynchburg VA 24505 804-528-4722 1-800-552-7676	Amherst County Appomattox County Campbell County Halifax County Lynchburg
Virginia Legal Aid Society 105 S. Union Street, Suite 400 Danville VA 24541 804-799-3550 1-800-552-7676	Danville Martinsville Henry County Patrick County Pittsylvania County
Virginia Legal Aid Society, Inc. 104 High Street Farmville VA 23901 804-392-8108 1-800-552-7676	Amelia County Buckingham County Charlotte County Cumberland County Lunenburg County Mecklenburg County Nottoway County Prince Edward County
Virginia Legal Aid Society, Inc. 112 W. Washington Street, Suite 300 P.O. Box 3356 Suffolk VA 23434 757-539-3441 1-800-552-7676	Franklin Isle of Wight County Smithfield Southampton Suffolk
Virginia Legal Aid Society, Inc. 412 South Main Street Emporia VA 23847 804-634-5172 1-800-552-7676	Brunswick County Emporia Greensville County Sussex County
Legal Aid Justice Center 1000 Preston Avenue, Suite A Charlottesville VA 22903 (434) 296-8851 1-800-200-8479	State of Virginia for Farm Workers and Low Wage Immigrants
Legal Services Corporation of Virginia 700 E. Main Street, Suite 1504 Richmond, VA 23219 (804) 782-9438	State of Virginia

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<u>Name and Address</u>	<u>Areas Served</u>
Virginia Poverty Law Center, Inc. 201 W. Broad Street, Suite 302 Richmond, VA 23220 (804) 782-9430 1-800-868-8752	State of Virginia

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PART XXIII

BENEFIT ALLOTMENTS

<u>CHAPTER</u>	<u>SUBJECT</u>	<u>PAGES</u>
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B.	BENEFIT ALLOTMENT TABLES	1-31

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A. CALCULATING BENEFIT ALLOTMENTS

The tables on the following pages show the appropriate benefits for household sizes 1 through 10.

For household sizes 1 and 2, \$10 is the minimum allotment for all eligible households, including PA categorically eligible households. The maximum monthly net income does not apply to categorically eligible households however.

For household sizes 3 through 10, the allotment tables are calculated from the maximum coupon allotment to the \$2 minimum allotment. NOTE: ONLY PA CATEGORICALLY ELIGIBLE HOUSEHOLDS ARE ELIGIBLE FOR ALLOTMENTS WHERE THE HOUSEHOLD'S NET INCOME EXCEEDS THE NET INCOME MAXIMUM. For example, for a 4-person household, the maximum net income is **\$1,534**. The allotment offered at that level of income is **\$10**. The rest of the allotment table, from the net income of **\$1,535** through **\$1,566**, the last income figure, for which an allotment is available, applies to PA categorically eligible households only.

To calculate issuances to households of more than ten persons, use the following formula:

1. Maximum Benefit Allotment. If there are more than ten household members, add **\$106** to the monthly maximum benefit allotment.
2. Maximum Monthly Net Income. If there are more than ten household members, add **\$262** to the monthly maximum net income. NOTE: Maximum monthly net income limits do not apply to PA categorically eligible households.

There will be occasions when a household is entitled to an allotment of \$1, \$3, or \$5. This can occur when a supplement, replacement or restoration is given, or when an allotment reduction calculation results in entitlement to \$1, \$3, or \$5. Raise allotments of \$1, \$3 or \$5 to the next dollar amount, namely \$2, \$4 or \$6 respectively.

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
0	-	0	141	259	371	471	560	672	743	849	955	1061
1	-	3	140	258	370	470	559	671	742	848	954	1060
4	-	6	139	257	369	469	558	670	741	847	953	1059
7	-	10	138	256	368	468	557	669	740	846	952	1058
11	-	13	137	255	367	467	556	668	739	845	951	1057
14	-	16	136	254	366	466	555	667	738	844	950	1056
17	-	20	135	253	365	465	554	666	737	843	949	1055
21	-	23	134	252	364	464	553	665	736	842	948	1054
24	-	26	133	251	363	463	552	664	735	841	947	1053
27	-	30	132	250	362	462	551	663	734	840	946	1052
31	-	33	131	249	361	461	550	662	733	839	945	1051
34	-	36	130	248	360	460	549	661	732	838	944	1050
37	-	40	129	247	359	459	548	660	731	837	943	1049
41	-	43	128	246	358	458	547	659	730	836	942	1048
44	-	46	127	245	357	457	546	658	729	835	941	1047
47	-	50	126	244	356	456	545	657	728	834	940	1046
51	-	53	125	243	355	455	544	656	727	833	939	1045
54	-	56	124	242	354	454	543	655	726	832	938	1044
57	-	60	123	241	353	453	542	654	725	831	937	1043
61	-	63	122	240	352	452	541	653	724	830	936	1042
64	-	66	121	239	351	451	540	652	723	829	935	1041
67	-	70	120	238	350	450	539	651	722	828	934	1040
71	-	73	119	237	349	449	538	650	721	827	933	1039
74	-	76	118	236	348	448	537	649	720	826	932	1038
77	-	80	117	235	347	447	536	648	719	825	931	1037
81	-	83	116	234	346	446	535	647	718	824	930	1036
84	-	86	115	233	345	445	534	646	717	823	929	1035
87	-	90	114	232	344	444	533	645	716	822	928	1034
91	-	93	113	231	343	443	532	644	715	821	927	1033
94	-	96	112	230	342	442	531	643	714	820	926	1032
97	-	100	111	229	341	441	530	642	713	819	925	1031
101	-	103	110	228	340	440	529	641	712	818	924	1030
104	-	106	109	227	339	439	528	640	711	817	923	1029
107	-	110	108	226	338	438	527	639	710	816	922	1028
111	-	113	107	225	337	437	526	638	709	815	921	1027

BASIS OF BENEFIT ISSUANCE
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BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
114	-	116	106	224	336	436	525	637	708	814	920	1026
117	-	120	105	223	335	435	524	636	707	813	919	1025
121	-	123	104	222	334	434	523	635	706	812	918	1024
124	-	126	103	221	333	433	522	634	705	811	917	1023
127	-	130	102	220	332	432	521	633	704	810	916	1022
131	-	133	101	219	331	431	520	632	703	809	915	1021
134	-	136	100	218	330	430	519	631	702	808	914	1020
137	-	140	99	217	329	429	518	630	701	807	913	1019
141	-	143	98	216	328	428	517	629	700	806	912	1018
144	-	146	97	215	327	427	516	628	699	805	911	1017
147	-	150	96	214	326	426	515	627	698	804	910	1016
151	-	153	95	213	325	425	514	626	697	803	909	1015
154	-	156	94	212	324	424	513	625	696	802	908	1014
157	-	160	93	211	323	423	512	624	695	801	907	1013
161	-	163	92	210	322	422	511	623	694	800	906	1012
164	-	166	91	209	321	421	510	622	693	799	905	1011
167	-	170	90	208	320	420	509	621	692	798	904	1010
171	-	173	89	207	319	419	508	620	691	797	903	1009
174	-	176	88	206	318	418	507	619	690	796	902	1008
177	-	180	87	205	317	417	506	618	689	795	901	1007
181	-	183	86	204	316	416	505	617	688	794	900	1006
184	-	186	85	203	315	415	504	616	687	793	899	1005
187	-	190	84	202	314	414	503	615	686	792	898	1004
191	-	193	83	201	313	413	502	614	685	791	897	1003
194	-	196	82	200	312	412	501	613	684	790	896	1002
197	-	200	81	199	311	411	500	612	683	789	895	1001
201	-	203	80	198	310	410	499	611	682	788	894	1000
204	-	206	79	197	309	409	498	610	681	787	893	999
207	-	210	78	196	308	408	497	609	680	786	892	998
211	-	213	77	195	307	407	496	608	679	785	891	997
214	-	216	76	194	306	406	495	607	678	784	890	996
217	-	220	75	193	305	405	494	606	677	783	889	995
221	-	223	74	192	304	404	493	605	676	782	888	994
224	-	226	73	191	303	403	492	604	675	781	887	993
227	-	230	72	190	302	402	491	603	674	780	886	992

BASIS OF BENEFIT ISSUANCE
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BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
231	-	233	71	189	301	401	490	602	673	779	885	991
234	-	236	70	188	300	400	489	601	672	778	884	990
237	-	240	69	187	299	399	488	600	671	777	883	989
241	-	243	68	186	298	398	487	599	670	776	882	988
244	-	246	67	185	297	397	486	598	669	775	881	987
247	-	250	66	184	296	396	485	597	668	774	880	986
251	-	253	65	183	295	395	484	596	667	773	879	985
254	-	256	64	182	294	394	483	595	666	772	878	984
257	-	260	63	181	293	393	482	594	665	771	877	983
261	-	263	62	180	292	392	481	593	664	770	876	982
264	-	266	61	179	291	391	480	592	663	769	875	981
267	-	270	60	178	290	390	479	591	662	768	874	980
271	-	273	59	177	289	389	478	590	661	767	873	979
274	-	276	58	176	288	388	477	589	660	766	872	978
277	-	280	57	175	287	387	476	588	659	765	871	977
281	-	283	56	174	286	386	475	587	658	764	870	976
284	-	286	55	173	285	385	474	586	657	763	869	975
287	-	290	54	172	284	384	473	585	656	762	868	974
291	-	293	53	171	283	383	472	584	655	761	867	973
294	-	296	52	170	282	382	471	583	654	760	866	972
297	-	300	51	169	281	381	470	582	653	759	865	971
301	-	303	50	168	280	380	469	581	652	758	864	970
304	-	306	49	167	279	379	468	580	651	757	863	969
307	-	310	48	166	278	378	467	579	650	756	862	968
311	-	313	47	165	277	377	466	578	649	755	861	967
314	-	316	46	164	276	376	465	577	648	754	860	966
317	-	320	45	163	275	375	464	576	647	753	859	965
321	-	323	44	162	274	374	463	575	646	752	858	964
324	-	326	43	161	273	373	462	574	645	751	857	963
327	-	330	42	160	272	372	461	573	644	750	856	962
331	-	333	41	159	271	371	460	572	643	749	855	961
334	-	336	40	158	270	370	459	571	642	748	854	960
337	-	340	39	157	269	369	458	570	641	747	853	959
341	-	343	38	156	268	368	457	569	640	746	852	958
344	-	346	37	155	267	367	456	568	639	745	851	957

BASIS OF BENEFIT ISSUANCE
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BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
347	-	350	36	154	266	366	455	567	638	744	850	956
351	-	353	35	153	265	365	454	566	637	743	849	955
354	-	356	34	152	264	364	453	565	636	742	848	954
357	-	360	33	151	263	363	452	564	635	741	847	953
361	-	363	32	150	262	362	451	563	634	740	846	952
364	-	366	31	149	261	361	450	562	633	739	845	951
367	-	370	30	148	260	360	449	561	632	738	844	950
371	-	373	29	147	259	359	448	560	631	737	843	949
374	-	376	28	146	258	358	447	559	630	736	842	948
377	-	380	27	145	257	357	446	558	629	735	841	947
381	-	383	26	144	256	356	445	557	628	734	840	946
384	-	386	25	143	255	355	444	556	627	733	839	945
387	-	390	24	142	254	354	443	555	626	732	838	944
391	-	393	23	141	253	353	442	554	625	731	837	943
394	-	396	22	140	252	352	441	553	624	730	836	942
397	-	400	21	139	251	351	440	552	623	729	835	941
401	-	403	20	138	250	350	439	551	622	728	834	940
404	-	406	19	137	249	349	438	550	621	727	833	939
407	-	410	18	136	248	348	437	549	620	726	832	938
411	-	413	17	135	247	347	436	548	619	725	831	937
414	-	416	16	134	246	346	435	547	618	724	830	936
417	-	420	15	133	245	345	434	546	617	723	829	935
421	-	423	14	132	244	344	433	545	616	722	828	934
424	-	426	13	131	243	343	432	544	615	721	827	933
427	-	430	12	130	242	342	431	543	614	720	826	932
431	-	433	11	129	241	341	430	542	613	719	825	931
434	-	436	10	128	240	340	429	541	612	718	824	930
437	-	440	10	127	239	339	428	540	611	717	823	929
441	-	443	10	126	238	338	427	539	610	716	822	928
444	-	446	10	125	237	337	426	538	609	715	821	927
447	-	450	10	124	236	336	425	537	608	714	820	926
451	-	453	10	123	235	335	424	536	607	713	819	925
454	-	456	10	122	234	334	423	535	606	712	818	924
457	-	460	10	121	233	333	422	534	605	711	817	923
461	-	463	10	120	232	332	421	533	604	710	816	922

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
464	-	466	10	119	231	331	420	532	603	709	815	921
467	-	470	10	118	230	330	419	531	602	708	814	920
471	-	473	10	117	229	329	418	530	601	707	813	919
474	-	476	10	116	228	328	417	529	600	706	812	918
477	-	480	10	115	227	327	416	528	599	705	811	917
481	-	483	10	114	226	326	415	527	598	704	810	916
484	-	486	10	113	225	325	414	526	597	703	809	915
487	-	490	10	112	224	324	413	525	596	702	808	914
491	-	493	10	111	223	323	412	524	595	701	807	913
494	-	496	10	110	222	322	411	523	594	700	806	912
497	-	500	10	109	221	321	410	522	593	699	805	911
501	-	503	10	108	220	320	409	521	592	698	804	910
504	-	506	10	107	219	319	408	520	591	697	803	909
507	-	510	10	106	218	318	407	519	590	696	802	908
511	-	513	10	105	217	317	406	518	589	695	801	907
514	-	516	10	104	216	316	405	517	588	694	800	906
517	-	520	10	103	215	315	404	516	587	693	799	905
521	-	523	10	102	214	314	403	515	586	692	798	904
524	-	526	10	101	213	313	402	514	585	691	797	903
527	-	530	10	100	212	312	401	513	584	690	796	902
531	-	533	10	99	211	311	400	512	583	689	795	901
534	-	536	10	98	210	310	399	511	582	688	794	900
537	-	540	10	97	209	309	398	510	581	687	793	899
541	-	543	10	96	208	308	397	509	580	686	792	898
544	-	546	10	95	207	307	396	508	579	685	791	897
547	-	550	10	94	206	306	395	507	578	684	790	896
551	-	553	10	93	205	305	394	506	577	683	789	895
554	-	556	10	92	204	304	393	505	576	682	788	894
557	-	560	10	91	203	303	392	504	575	681	787	893
561	-	563	10	90	202	302	391	503	574	680	786	892
564	-	566	10	89	201	301	390	502	573	679	785	891
567	-	570	10	88	200	300	389	501	572	678	784	890
571	-	573	10	87	199	299	388	500	571	677	783	889
574	-	576	10	86	198	298	387	499	570	676	782	888
577	-	580	10	85	197	297	386	498	569	675	781	887

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
581	-	583	10	84	196	296	385	497	568	674	780	886
584	-	586	10	83	195	295	384	496	567	673	779	885
587	-	590	10	82	194	294	383	495	566	672	778	884
591	-	593	10	81	193	293	382	494	565	671	777	883
594	-	596	10	80	192	292	381	493	564	670	776	882
597	-	600	10	79	191	291	380	492	563	669	775	881
601	-	603	10	78	190	290	379	491	562	668	774	880
604	-	606	10	77	189	289	378	490	561	667	773	879
607	-	610	10	76	188	288	377	489	560	666	772	878
611	-	613	10	75	187	287	376	488	559	665	771	877
614	-	616	10	74	186	286	375	487	558	664	770	876
617	-	620	10	73	185	285	374	486	557	663	769	875
621	-	623	10	72	184	284	373	485	556	662	768	874
624	-	626	10	71	183	283	372	484	555	661	767	873
627	-	630	10	70	182	282	371	483	554	660	766	872
631	-	633	10	69	181	281	370	482	553	659	765	871
634	-	636	10	68	180	280	369	481	552	658	764	870
637	-	640	10	67	179	279	368	480	551	657	763	869
641	-	643	10	66	178	278	367	479	550	656	762	868
644	-	646	10	65	177	277	366	478	549	655	761	867
647	-	650	10	64	176	276	365	477	548	654	760	866
651	-	653	10	63	175	275	364	476	547	653	759	865
654	-	656	10	62	174	274	363	475	546	652	758	864
657	-	660	10	61	173	273	362	474	545	651	757	863
661	-	663	10	60	172	272	361	473	544	650	756	862
664	-	666	10	59	171	271	360	472	543	649	755	861
667	-	670	10	58	170	270	359	471	542	648	754	860
671	-	673	10	57	169	269	358	470	541	647	753	859
674	-	676	10	56	168	268	357	469	540	646	752	858
677	-	680	10	55	167	267	356	468	539	645	751	857
681	-	683	10	54	166	266	355	467	538	644	750	856
684	-	686	10	53	165	265	354	466	537	643	749	855
687	-	690	10	52	164	264	353	465	536	642	748	854
691	-	693	10	51	163	263	352	464	535	641	747	853
694	-	696	10	50	162	262	351	463	534	640	746	852

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
697	-	700	10	49	161	261	350	462	533	639	745	851
701	-	703	10	48	160	260	349	461	532	638	744	850
704	-	706	10	47	159	259	348	460	531	637	743	849
707	-	710	10	46	158	258	347	459	530	636	742	848
711	-	713	10	45	157	257	346	458	529	635	741	847
714	-	716	10	44	156	256	345	457	528	634	740	846
717	-	720	10	43	155	255	344	456	527	633	739	845
721	-	723	10	42	154	254	343	455	526	632	738	844
724	-	726	10	41	153	253	342	454	525	631	737	843
727	-	730	10	40	152	252	341	453	524	630	736	842
731	-	733	10	39	151	251	340	452	523	629	735	841
734	-	736	10	38	150	250	339	451	522	628	734	840
737	-	740	10	37	149	249	338	450	521	627	733	839
741	-	743	10	36	148	248	337	449	520	626	732	838
744	-	746	10	35	147	247	336	448	519	625	731	837
747	-	750*	10*	34	146	246	335	447	518	624	730	836
751	-	753	10	33	145	245	334	446	517	623	729	835
754	-	756	10	32	144	244	333	445	516	622	728	834
757	-	760	10	31	143	243	332	444	515	621	727	833
761	-	763	10	30	142	242	331	443	514	620	726	832
764	-	766	10	29	141	241	330	442	513	619	725	831
767	-	770	10	28	140	240	329	441	512	618	724	830
771	-	773	10	27	139	239	328	440	511	617	723	829
774	-	776	10	26	138	238	327	439	510	616	722	828
777	-	780	10	25	137	237	326	438	509	615	721	827
781	-	783	10	24	136	236	325	437	508	614	720	826
784	-	786	10	23	135	235	324	436	507	613	719	825
787	-	790	10	22	134	234	323	435	506	612	718	824
791	-	793	10	21	133	233	322	434	505	611	717	823
794	-	796	10	20	132	232	321	433	504	610	716	822
797	-	800	10	19	131	231	320	432	503	609	715	821
801	-	803	10	18	130	230	319	431	502	608	714	820
804	-	806	10	17	129	229	318	430	501	607	713	819
807	-	810	10	16	128	228	317	429	500	606	712	818
811	-	813	10	15	127	227	316	428	499	605	711	817

*Net Income Limit \$749

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
814	-	816	10	14	126	226	315	427	498	604	710	816
817	-	820	10	13	125	225	314	426	497	603	709	815
821	-	823	10	12	124	224	313	425	496	602	708	814
824	-	826	10	11	123	223	312	424	495	601	707	813
827	-	830	10	10	122	222	311	423	494	600	706	812
831	-	833	10	10	121	221	310	422	493	599	705	811
834	-	836	10	10	120	220	309	421	492	598	704	810
837	-	840	10	10	119	219	308	420	491	597	703	809
841	-	843	10	10	118	218	307	419	490	596	702	808
844	-	846	10	10	117	217	306	418	489	595	701	807
847	-	850	10	10	116	216	305	417	488	594	700	806
851	-	853	10	10	115	215	304	416	487	593	699	805
854	-	856	10	10	114	214	303	415	486	592	698	804
857	-	860	10	10	113	213	302	414	485	591	697	803
861	-	863	10	10	112	212	301	413	484	590	696	802
864	-	866	10	10	111	211	300	412	483	589	695	801
867	-	870	10	10	110	210	299	411	482	588	694	800
871	-	873	10	10	109	209	298	410	481	587	693	799
874	-	876	10	10	108	208	297	409	480	586	692	798
877	-	880	10	10	107	207	296	408	479	585	691	797
881	-	883	10	10	106	206	295	407	478	584	690	796
884	-	886	10	10	105	205	294	406	477	583	689	795
887	-	890	10	10	104	204	293	405	476	582	688	794
891	-	893	10	10	103	203	292	404	475	581	687	793
894	-	896	10	10	102	202	291	403	474	580	686	792
897	-	900	10	10	101	201	290	402	473	579	685	791
901	-	903	10	10	100	200	289	401	472	578	684	790
904	-	906	10	10	99	199	288	400	471	577	683	789
907	-	910	10	10	98	198	287	399	470	576	682	788
911	-	913	10	10	97	197	286	398	469	575	681	787
914	-	916	10	10	96	196	285	397	468	574	680	786
917	-	920	10	10	95	195	284	396	467	573	679	785
921	-	923	10	10	94	194	283	395	466	572	678	784
924	-	926	10	10	93	193	282	394	465	571	677	783
927	-	930	10	10	92	192	281	393	464	570	676	782

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
931	-	933	10	10	91	191	280	392	463	569	675	781
934	-	936	10	10	90	190	279	391	462	568	674	780
937	-	940	10	10	89	189	278	390	461	567	673	779
941	-	943	10	10	88	188	277	389	460	566	672	778
944	-	946	10	10	87	187	276	388	459	565	671	777
947	-	950	10	10	86	186	275	387	458	564	670	776
951	-	953	10	10	85	185	274	386	457	563	669	775
954	-	956	10	10	84	184	273	385	456	562	668	774
957	-	960	10	10	83	183	272	384	455	561	667	773
961	-	963	10	10	82	182	271	383	454	560	666	772
964	-	966	10	10	81	181	270	382	453	559	665	771
967	-	970	10	10	80	180	269	381	452	558	664	770
971	-	973	10	10	79	179	268	380	451	557	663	769
974	-	976	10	10	78	178	267	379	450	556	662	768
977	-	980	10	10	77	177	266	378	449	555	661	767
981	-	983	10	10	76	176	265	377	448	554	660	766
984	-	986	10	10	75	175	264	376	447	553	659	765
987	-	990	10	10	74	174	263	375	446	552	658	764
991	-	993	10	10	73	173	262	374	445	551	657	763
994	-	996	10	10	72	172	261	373	444	550	656	762
997	-	1000	10	10	71	171	260	372	443	549	655	761
1001	-	1003	10	10	70	170	259	371	442	548	654	760
1004	-	1006	10	10	69	169	258	370	441	547	653	759
1007	-	1010*	10	10*	68	168	257	369	440	546	652	758
1011	-	1013	10	10	67	167	256	368	439	545	651	757
1014	-	1016	10	10	66	166	255	367	438	544	650	756
1017	-	1020	10	10	65	165	254	366	437	543	649	755
1021	-	1023	10	10	64	164	253	365	436	542	648	754
1024	-	1026	10	10	63	163	252	364	435	541	647	753
1027	-	1030	10	10	62	162	251	363	434	540	646	752
1031	-	1033	10	10	61	161	250	362	433	539	645	751
1034	-	1036	10	10	60	160	249	361	432	538	644	750
1037	-	1040	10	10	59	159	248	360	431	537	643	749
1041	-	1043	10	10	58	158	247	359	430	536	642	748
1044	-	1046	10	10	57	157	246	358	429	535	641	747

*Net Income Limit

\$1,010

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1047	-	1050	10	10	56	156	245	357	428	534	640	746
1051	-	1053	10	10	55	155	244	356	427	533	639	745
1054	-	1056	10	10	54	154	243	355	426	532	638	744
1057	-	1060	10	10	53	153	242	354	425	531	637	743
1061	-	1063	10	10	52	152	241	353	424	530	636	742
1064	-	1066	10	10	51	151	240	352	423	529	635	741
1067	-	1070	10	10	50	150	239	351	422	528	634	740
1071	-	1073	10	10	49	149	238	350	421	527	633	739
1074	-	1076	10	10	48	148	237	349	420	526	632	738
1077	-	1080	10	10	47	147	236	348	419	525	631	737
1081	-	1083	10	10	46	146	235	347	418	524	630	736
1084	-	1086	10	10	45	145	234	346	417	523	629	735
1087	-	1090	10	10	44	144	233	345	416	522	628	734
1091	-	1093	10	10	43	143	232	344	415	521	627	733
1094	-	1096	10	10	42	142	231	343	414	520	626	732
1097	-	1100	10	10	41	141	230	342	413	519	625	731
1101	-	1103	10	10	40	140	229	341	412	518	624	730
1104	-	1106	10	10	39	139	228	340	411	517	623	729
1107	-	1110	10	10	38	138	227	339	410	516	622	728
1111	-	1113	10	10	37	137	226	338	409	515	621	727
1114	-	1116	10	10	36	136	225	337	408	514	620	726
1117	-	1120	10	10	35	135	224	336	407	513	619	725
1121	-	1123	10	10	34	134	223	335	406	512	618	724
1124	-	1126	10	10	33	133	222	334	405	511	617	723
1127	-	1130	10	10	32	132	221	333	404	510	616	722
1131	-	1133	10	10	31	131	220	332	403	509	615	721
1134	-	1136	10	10	30	130	219	331	402	508	614	720
1137	-	1140	10	10	29	129	218	330	401	507	613	719
1141	-	1143	10	10	28	128	217	329	400	506	612	718
1144	-	1146	10	10	27	127	216	328	399	505	611	717
1147	-	1150	10	10	26	126	215	327	398	504	610	716
1151	-	1153	10	10	25	125	214	326	397	503	609	715
1154	-	1156	10	10	24	124	213	325	396	502	608	714
1157	-	1160	10	10	23	123	212	324	395	501	607	713
1161	-	1163	10	10	22	122	211	323	394	500	606	712

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1164	-	1166	10	10	21	121	210	322	393	499	605	711
1167	-	1170	10	10	20	120	209	321	392	498	604	710
1171	-	1173	10	10	19	119	208	320	391	497	603	709
1174	-	1176	10	10	18	118	207	319	390	496	602	708
1177	-	1180	10	10	17	117	206	318	389	495	601	707
1181	-	1183	10	10	16	116	205	317	388	494	600	706
1184	-	1186	10	10	15	115	204	316	387	493	599	705
1187	-	1190	10	10	14	114	203	315	386	492	598	704
1191	-	1193	10	10	13	113	202	314	385	491	597	703
1194	-	1196	10	10	12	112	201	313	384	490	596	702
1197	-	1200	10	10	11	111	200	312	383	489	595	701
1201	-	1203	10	10	10	110	199	311	382	488	594	700
1204	-	1206	10	10	9	109	198	310	381	487	593	699
1207	-	1210	10	10	8	108	197	309	380	486	592	698
1211	-	1213	10	10	7	107	196	308	379	485	591	697
1214	-	1216	10	10	6	106	195	307	378	484	590	696
1217	-	1220	10	10	6	105	194	306	377	483	589	695
1221	-	1223	10	10	4	104	193	305	376	482	588	694
1224	-	1226	10	10	4	103	192	304	375	481	587	693
1227	-	1230	10	10	2	102	191	303	374	480	586	692
1231	-	1233	10	10	2	101	190	302	373	479	585	691
1234	-	1236	10	10		100	189	301	372	478	584	690
1237	-	1240		10		99	188	300	371	477	583	689
1241	-	1243		10		98	187	299	370	476	582	688
1244	-	1246		10		97	186	298	369	475	581	687
1247	-	1250		10		96	185	297	368	474	580	686
1251	-	1253		10		95	184	296	367	473	579	685
1254	-	1256		10		94	183	295	366	472	578	684
1257	-	1260		10		93	182	294	365	471	577	683
1261	-	1263		10		92	181	293	364	470	576	682
1264	-	1266		10		91	180	292	363	469	575	681
1267	-	1270		10		90	179	291	362	468	574	680
1271	-	1273*		10	*	89	178	290	361	467	573	679
1274	-	1276		10		88	177	289	360	466	572	678
1277	-	1280		10		87	176	288	359	465	571	677

*Net Income Limit

\$1,272

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1281	-	1283		10		86	175	287	358	464	570	676
1284	-	1286		10		85	174	286	357	463	569	675
1287	-	1290		10		84	173	285	356	462	568	674
1291	-	1293		10		83	172	284	355	461	567	673
1294	-	1296		10		82	171	283	354	460	566	672
1297	-	1300		10		81	170	282	353	459	565	671
1301	-	1303		10		80	169	281	352	458	564	670
1304	-	1306		10		79	168	280	351	457	563	669
1307	-	1310		10		78	167	279	350	456	562	668
1311	-	1313		10		77	166	278	349	455	561	667
1314	-	1316		10		76	165	277	348	454	560	666
1317	-	1320		10		75	164	276	347	453	559	665
1321	-	1323		10		74	163	275	346	452	558	664
1324	-	1326		10		73	162	274	345	451	557	663
1327	-	1330		10		72	161	273	344	450	556	662
1331	-	1333		10		71	160	272	343	449	555	661
1334	-	1336		10		70	159	271	342	448	554	660
1337	-	1340		10		69	158	270	341	447	553	659
1341	-	1343		10		68	157	269	340	446	552	658
1344	-	1346		10		67	156	268	339	445	551	657
1347	-	1350		10		66	155	267	338	444	550	656
1351	-	1353		10		65	154	266	337	443	549	655
1354	-	1356		10		64	153	265	336	442	548	654
1357	-	1360		10		63	152	264	335	441	547	653
1361	-	1363		10		62	151	263	334	440	546	652
1364	-	1366		10		61	150	262	333	439	545	651
1367	-	1370		10		60	149	261	332	438	544	650
1371	-	1373		10		59	148	260	331	437	543	649
1374	-	1376		10		58	147	259	330	436	542	648
1377	-	1380		10		57	146	258	329	435	541	647
1381	-	1383		10		56	145	257	328	434	540	646
1384	-	1386		10		55	144	256	327	433	539	645
1387	-	1390		10		54	143	255	326	432	538	644
1391	-	1393		10		53	142	254	325	431	537	643
1394	-	1396		10		52	141	253	324	430	536	642

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1397	-	1400		10		51	140	252	323	429	535	641
1400	-	1403		10		50	139	251	322	428	534	640
1404	-	1406		10		49	138	250	321	427	533	639
1407	-	1410		10		48	137	249	320	426	532	638
1411	-	1413		10		47	136	248	319	425	531	637
1414	-	1416		10		46	135	247	318	424	530	636
1417	-	1420		10		45	134	246	317	423	529	635
1421	-	1423		10		44	133	245	316	422	528	634
1424	-	1426		10		43	132	244	315	421	527	633
1427	-	1430		10		42	131	243	314	420	526	632
1431	-	1433		10		41	130	242	313	419	525	631
1434	-	1436		10		40	129	241	312	418	524	630
1437	-	1440		10		39	128	240	311	417	523	629
1441	-	1443		10		38	127	239	310	416	522	628
1444	-	1446		10		37	126	238	309	415	521	627
1447	-	1450		10		36	125	237	308	414	520	626
1451	-	1453		10		35	124	236	307	413	519	625
1454	-	1456		10		34	123	235	306	412	518	624
1457	-	1460		10		33	122	234	305	411	517	623
1461	-	1463		10		32	121	233	304	410	516	622
1464	-	1466		10		31	120	232	303	409	515	621
1467	-	1470		10		30	119	231	302	408	514	620
1471	-	1473		10		29	118	230	301	407	513	619
1474	-	1476		10		28	117	229	300	406	512	618
1477	-	1480		10		27	116	228	299	405	511	617
1481	-	1483		10		26	115	227	298	404	510	616
1484	-	1486		10		25	114	226	297	403	509	615
1487	-	1490		10		24	113	225	296	402	508	614
1491	-	1493		10		23	112	224	295	401	507	613
1494	-	1496		10		22	111	223	294	400	506	612
1497	-	1500		10		21	110	222	293	399	505	611
1501	-	1503		10		20	109	221	292	398	504	610
1504	-	1506		10		19	108	220	291	397	503	609
1507	-	1510		10		18	107	219	290	396	502	608
1511	-	1513		10		17	106	218	289	395	501	607

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1514	-	1516		10		16	105	217	288	394	500	606
1517	-	1520		10		15	104	216	287	393	499	605
1521	-	1523		10		14	103	215	286	392	498	604
1524	-	1526		10		13	102	214	285	391	497	603
1527	-	1530		10		12	101	213	284	390	496	602
1531	-	1533		10		11	100	212	283	389	495	601
1534	-	1536*		10		10*	99	211	282	388	494	600
1537	-	1540		10		9	98	210	281	387	493	599
1541	-	1543		10		8	97	209	280	386	492	598
1544	-	1546		10		7	96	208	279	385	491	597
1547	-	1550		10		6	95	207	278	384	490	596
1551	-	1553		10		6	94	206	277	383	489	595
1554	-	1556		10		4	93	205	276	382	488	594
1557	-	1560		10		4	92	204	275	381	487	593
1561	-	1563		10		2	91	203	274	380	486	592
1564	-	1566		10		2	90	202	273	379	485	591
1567	-	1570		10			89	201	272	378	484	590
1571	-	1573		10			88	200	271	377	483	589
1574	-	1576		10			87	199	270	376	482	588
1577	-	1580		10			86	198	269	375	481	587
1581	-	1583		10			85	197	268	374	480	586
1584	-	1586		10			84	196	267	373	479	585
1587	-	1590		10			83	195	266	372	478	584
1591	-	1593		10			82	194	265	371	477	583
1594	-	1596		10			81	193	264	370	476	582
1597	-	1600		10			80	192	263	369	475	581
1601	-	1603		10			79	191	262	368	474	580
1604	-	1606		10			78	190	261	367	473	579
1607	-	1610		10			77	189	260	366	472	578
1611	-	1613		10			76	188	259	365	471	577
1614	-	1616		10			75	187	258	364	470	576
1617	-	1620		10			74	186	257	363	469	575
1621	-	1623		10			73	185	256	362	468	574
1624	-	1626		10			72	184	255	361	467	573
1627	-	1630		10			71	183	254	360	466	572

*Net Income Limit

\$1,534

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1631	-	1633		10			70	182	253	359	465	571
1634	-	1636		10			69	181	252	358	464	570
1637	-	1640		10			68	180	251	357	463	569
1641	-	1643		10			67	179	250	356	462	568
1644	-	1646		10			66	178	249	355	461	567
1647	-	1650		10			65	177	248	354	460	566
1651	-	1653		10			64	176	247	353	459	565
1654	-	1656		10			63	175	246	352	458	564
1657	-	1660		10			62	174	245	351	457	563
1661	-	1663		10			61	173	244	350	456	562
1664	-	1666		10			60	172	243	349	455	561
1667	-	1670		10			59	171	242	348	454	560
1671	-	1673					58	170	241	347	453	559
1674	-	1676					57	169	240	346	452	558
1677	-	1680					56	168	239	345	451	557
1681	-	1683					55	167	238	344	450	556
1684	-	1686					54	166	237	343	449	555
1687	-	1690					53	165	236	342	448	554
1691	-	1693					52	164	235	341	447	553
1694	-	1696					51	163	234	340	446	552
1697	-	1700					50	162	233	339	445	551
1701	-	1703					49	161	232	338	444	550
1704	-	1706					48	160	231	337	443	549
1707	-	1710					47	159	230	336	442	548
1711	-	1713					46	158	229	335	441	547
1714	-	1716					45	157	228	334	440	546
1717	-	1720					44	156	227	333	439	545
1721	-	1723					43	155	226	332	438	544
1724	-	1726					42	154	225	331	437	543
1727	-	1730					41	153	224	330	436	542
1731	-	1733					40	152	223	329	435	541
1734	-	1736					39	151	222	328	434	540
1737	-	1740					38	150	221	327	433	539
1741	-	1743					37	149	220	326	432	538
1744	-	1746					36	148	219	325	431	537

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME	ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1747 - 1750					35	147	218	324	430	536
1751 - 1753					34	146	217	323	429	535
1754 - 1756					33	145	216	322	428	534
1757 - 1760					32	144	215	321	427	533
1761 - 1763					31	143	214	320	426	532
1764 - 1765					30	142	213	319	425	531
1767 - 1770					29	141	212	318	424	530
1771 - 1773					28	140	211	317	423	529
1774 - 1776					27	139	210	316	422	528
1777 - 1780					26	138	209	315	421	527
1781 - 1783					25	137	208	314	420	526
1784 - 1786					24	136	207	313	419	525
1787 - 1790					23	135	206	312	418	524
1791 - 1793					22	134	205	311	417	523
1794 - 1796*					21	133	204	310	416	522
1797 - 1800					20	132	203	309	415	521
1801 - 1803					19	131	202	308	414	520
1804 - 1806					18	130	201	307	413	519
1807 - 1810					17	129	200	306	412	518
1811 - 1813					16	128	199	305	411	517
1814 - 1816					15	127	198	304	410	516
1817 - 1820					14	126	197	303	409	515
1821 - 1823					13	125	196	302	408	514
1824 - 1826					12	124	195	301	407	513
1827 - 1830					11	123	194	300	406	512
1831 - 1833					10	122	193	299	405	511
1834 - 1836					9	121	192	298	404	510
1837 - 1840					8	120	191	297	403	509
1841 - 1843					7	119	190	296	402	508
1844 - 1846					6	118	189	295	401	507
1847 - 1850					6	117	188	294	400	506
1851 - 1853					4	116	187	293	399	505
1854 - 1856					4	115	186	292	398	504
1857 - 1860					2	114	185	291	397	503
1861 - 1863					2	113	184	290	396	502

*Net Income Limit

\$1,795

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1864	-	1866						112	183	289	395	501
1867	-	1870						111	182	288	394	500
1871	-	1873						110	181	287	393	499
1874	-	1876						109	180	286	392	498
1877	-	1880						108	179	285	391	497
1881	-	1883						107	178	284	390	496
1884	-	1886						106	177	283	389	495
1887	-	1890						105	176	282	388	494
1891	-	1893						104	175	281	387	493
1894	-	1896						103	174	280	386	492
1897	-	1900						102	173	279	385	491
1901	-	1903						101	172	278	384	490
1904	-	1906						100	171	277	383	489
1907	-	1910						99	170	276	382	488
1911	-	1913						98	169	275	381	487
1914	-	1916						97	168	274	380	486
1917	-	1920						96	167	273	379	485
1921	-	1923						95	166	272	378	484
1924	-	1926						94	165	271	377	483
1927	-	1930						93	164	270	376	482
1931	-	1933						92	163	269	375	481
1934	-	1936						91	162	268	374	480
1937	-	1940						90	161	267	373	479
1941	-	1943						89	160	266	372	478
1944	-	1946						88	159	265	371	477
1947	-	1950						87	158	264	370	476
1951	-	1953						86	157	263	369	475
1954	-	1956						85	156	262	368	474
1957	-	1960						84	155	261	367	473
1961	-	1963						83	154	260	366	472
1964	-	1966						82	153	259	365	471
1967	-	1970						81	152	258	364	470
1971	-	1973						80	151	257	363	469
1974	-	1976						79	150	256	362	468
1977	-	1980						78	149	255	361	467

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
1981	-	1983						77	148	254	360	466
1984	-	1986						76	147	253	359	465
1987	-	1990						75	146	252	358	464
1991	-	1993						74	145	251	357	463
1994	-	1996						73	144	250	356	462
1997	-	2000						72	143	249	355	461
2001	-	2003						71	142	248	354	460
2004	-	2006						70	141	247	353	459
2007	-	2010						69	140	246	352	458
2011	-	2013						68	139	245	351	457
2014	-	2016						67	138	244	350	456
2017	-	2020						66	137	243	349	455
2021	-	2023						65	136	242	348	454
2024	-	2026						64	135	241	347	453
2027	-	2030						63	134	240	346	452
2031	-	2033						62	133	239	345	451
2034	-	2036						61	132	238	344	450
2037	-	2040						60	131	237	343	449
2041	-	2043						59	130	236	342	448
2044	-	2046						58	129	235	341	447
2047	-	2050						57	128	234	340	446
2051	-	2053						56	127	233	339	445
2054	-	2056						55	126	232	338	444
2057	-	2060*						54*	125	231	337	443
2061	-	2063						53	124	230	336	442
2064	-	2066						52	123	229	335	441
2067	-	2070						51	122	228	334	440
2071	-	2073						50	121	227	333	439
2074	-	2076						49	120	226	332	438
2077	-	2080						48	119	225	331	437
2081	-	2083						47	118	224	330	436
2084	-	2086						46	117	223	329	435
2087	-	2090						45	116	222	328	434
2091	-	2093						44	115	221	327	433
2094	-	2096						43	114	220	326	432

*Net Income Limit

\$2,057

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2097	-	2100						42	113	219	325	431
2101	-	2103						41	112	218	324	430
2104	-	2106						40	111	217	323	429
2107	-	2110						39	110	216	322	428
2111	-	2113						38	109	215	321	427
2114	-	2116						37	108	214	320	426
2117	-	2120						36	107	213	319	425
2121	-	2123						35	106	212	318	424
2124	-	2126						34	105	211	317	423
2127	-	2130						33	104	210	316	422
2131	-	2133						32	103	209	315	421
2134	-	2136						31	102	208	314	420
2137	-	2140						30	101	207	313	419
2141	-	2143						29	100	206	312	418
2144	-	2146						28	99	205	311	417
2147	-	2150						27	98	204	310	416
2151	-	2153						26	97	203	309	415
2154	-	2156						25	96	202	308	414
2157	-	2160						24	95	201	307	413
2161	-	2163						23	94	200	306	412
2164	-	2166						22	93	199	305	411
2167	-	2170						21	92	198	304	410
2171	-	2173						20	91	197	303	409
2174	-	2176						19	90	196	302	408
2177	-	2180						18	89	195	301	407
2181	-	2183						17	88	194	300	406
2184	-	2186						16	87	193	299	405
2187	-	2190						15	86	192	298	404
2191	-	2193						14	85	191	297	403
2194	-	2196						13	84	190	296	402
2197	-	2200						12	83	189	295	401
2201	-	2203						11	82	188	294	400
2204	-	2206						10	81	187	293	399
2207	-	2210						9	80	186	292	398
2211	-	2213						8	79	185	291	397

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2214	-	2216						7	78	184	290	396
2217	-	2220						6	77	183	289	395
2221	-	2223						6	76	182	288	394
2224	-	2226						4	75	181	287	393
2227	-	2230						4	74	180	286	392
2231	-	2233						2	73	179	285	391
2234	-	2236						2	72	178	284	390
2237	-	2240							71	177	283	389
2241	-	2243							70	176	282	388
2244	-	2246							69	175	281	387
2247	-	2250							68	174	280	386
2251	-	2253							67	173	279	385
2254	-	2256							66	172	278	384
2257	-	2260							65	171	277	383
2261	-	2263							64	170	276	382
2264	-	2266							63	169	275	381
2267	-	2270							62	168	274	380
2271	-	2273							61	167	273	379
2274	-	2276							60	166	272	378
2277	-	2280							59	165	271	377
2281	-	2283							58	164	270	376
2284	-	2286							57	163	269	375
2287	-	2290							56	162	268	374
2291	-	2293							55	161	267	373
2294	-	2296							54	160	266	372
2297	-	2300							53	159	265	371
2301	-	2303							52	158	264	370
2304	-	2306							51	157	263	369
2307	-	2310							50	156	262	368
2311	-	2313							49	155	261	367
2314	-	2316							48	154	260	366
2317	-	2320*							47*	153	259	365
2321	-	2323							46	152	258	364
2324	-	2326							45	151	257	363
2327	-	2330							44	150	256	362

*Net Income Limit

\$2,319

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2331	-	2333							43	149	255	361
2334	-	2336							42	148	254	360
2337	-	2340							41	147	253	359
2341	-	2343							40	146	252	358
2344	-	2346							39	145	251	357
2347	-	2350							38	144	250	356
2351	-	2353							37	143	249	355
2354	-	2356							36	142	248	354
2357	-	2360							35	141	247	353
2361	-	2363							34	140	246	352
2364	-	2366							33	139	245	351
2367	-	2370							32	138	244	350
2371	-	2373							31	137	243	349
2374	-	2376							30	136	242	348
2377	-	2380							29	135	241	347
2381	-	2383							28	134	240	346
2384	-	2386							27	133	239	345
2387	-	2390							26	132	238	344
2391	-	2393							25	131	237	343
2394	-	2396							24	130	236	342
2397	-	2400							23	129	235	341
2401	-	2403							22	128	234	340
2404	-	2406							21	127	233	339
2407	-	2410							20	126	232	338
2411	-	2413							19	125	231	337
2414	-	2416							18	124	230	336
2417	-	2420							17	123	229	335
2421	-	2423							16	122	228	334
2424	-	2426							15	121	227	333
2427	-	2430							14	120	226	332
2431	-	2433							13	119	225	331
2434	-	2436							12	118	224	330
2437	-	2440							11	117	223	329
2441	-	2443							10	116	222	328
2444	-	2446							9	115	221	327

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME	ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2447 - 2450							8	114	220	326
2451 - 2453							7	113	219	325
2454 - 2456							6	112	218	324
2457 - 2460							6	111	217	323
2461 - 2463							4	110	216	322
2464 - 2466							4	109	215	321
2467 - 2470							2	108	214	320
2471 - 2473							2	107	213	319
2474 - 2476								106	212	318
2477 - 2480								105	211	317
2481 - 2483								104	210	316
2484 - 2486								103	209	315
2487 - 2490								102	208	314
2491 - 2493								101	207	313
2494 - 2496								100	206	312
2497 - 2500								99	205	311
2501 - 2503								98	204	310
2504 - 2506								97	203	309
2507 - 2510								96	202	308
2511 - 2513								95	201	307
2514 - 2516								94	200	306
2517 - 2520								93	199	305
2521 - 2523								92	198	304
2524 - 2526								91	197	303
2527 - 2530								90	196	302
2531 - 2533								89	195	301
2534 - 2536								88	194	300
2537 - 2540								87	193	299
2541 - 2543								86	192	298
2544 - 2546								85	191	297
2547 - 2550								84	190	296
2551 - 2553								83	189	295
2554 - 2556								82	188	294
2557 - 2560								81	187	293
2561 - 2563								80	186	292

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2564	-	2566								79	185	291
2567	-	2570								78	184	290
2571	-	2573								77	183	289
2574	-	2576								76	182	288
2577	-	2580*								75*	181	287
2581	-	2583								74	180	286
2584	-	2586								73	179	285
2587	-	2590								72	178	284
2591	-	2593								71	177	283
2594	-	2596								70	176	282
2597	-	2600								69	175	281
2601	-	2603								68	174	280
2604	-	2606								67	173	279
2607	-	2610								66	172	278
2611	-	2613								65	171	277
2614	-	2616								64	170	276
2617	-	2620								63	169	275
2621	-	2623								62	168	274
2624	-	2626								61	167	273
2627	-	2630								60	166	272
2631	-	2633								59	165	271
2634	-	2636								58	164	270
2637	-	2640								57	163	269
2641	-	2643								56	162	268
2644	-	2646								55	161	267
2647	-	2650								54	160	266
2651	-	2653								53	159	265
2654	-	2656								52	158	264
2657	-	2660								51	157	263
2661	-	2663								50	156	262
2664	-	2666								49	155	261
2667	-	2670								48	154	260
2671	-	2673								47	153	259
2674	-	2676								46	152	258
2677	-	2680								45	151	257

*Net Income Limit

\$2,580

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2681	-	2683								44	150	256
2684	-	2686								43	149	255
2687	-	2690								42	148	254
2691	-	2693								41	147	253
2694	-	2696								40	146	252
2697	-	2700								39	145	251
2701	-	2703								38	144	250
2704	-	2706								37	143	249
2707	-	2710								36	142	248
2711	-	2713								35	141	247
2714	-	2716								34	140	246
2717	-	2720								33	139	245
2721	-	2723								32	138	244
2724	-	2726								31	137	243
2727	-	2730								30	136	242
2731	-	2733								29	135	241
2734	-	2736								28	134	240
2737	-	2740								27	133	239
2741	-	2743								26	132	238
2744	-	2746								25	131	237
2747	-	2750								24	130	236
2751	-	2753								23	129	235
2754	-	2756								22	128	234
2757	-	2760								21	127	233
2761	-	2763								20	126	232
2764	-	2766								19	125	231
2767	-	2770								18	124	230
2771	-	2773								17	123	229
2774	-	2776								16	122	228
2777	-	2780								15	121	227
2781	-	2783								14	120	226
2784	-	2786								13	119	225
2787	-	2790								12	118	224
2791	-	2793								11	117	223
2794	-	2796								10	116	222

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
2797	-	2800								9	115	221
2801	-	2803								8	114	220
2804	-	2806								7	113	219
2807	-	2810								6	112	218
2811	-	2813								6	111	217
2814	-	2816								4	110	216
2817	-	2820								4	109	215
2821	-	2823								2	108	214
2824	-	2826								2	107	213
2827	-	2830									106	212
2831	-	2833									105	211
2834	-	2836									104	210
2837	-	2840									103	209
2841	-	2843*									102*	208
2844	-	2846									101	207
2847	-	2850									100	206
2851	-	2853									99	205
2854	-	2856									98	204
2857	-	2860									97	203
2861	-	2863									96	202
2864	-	2866									95	201
2867	-	2870									94	200
2871	-	2873									93	199
2874	-	2876									92	198
2877	-	2880									91	197
2881	-	2883									90	196
2884	-	2886									89	195
2887	-	2890									88	194
2891	-	2893									87	193
2894	-	2896									86	192
2897	-	2900									85	191
2901	-	2903									84	190
2904	-	2906									83	189
2907	-	2910									82	188
2911	-	2913									81	187

*Net Income Limit

\$2,842

[illegible]

BASIS OF BENEFIT ISSUANCE
OCTOBER 2003

BENEFIT ALLOTMENTS BY HOUSEHOLD SIZE

MONTHLY NET INCOME			ONE PERSON	TWO PERSONS	THREE PERSONS	FOUR PERSONS	FIVE PERSONS	SIX PERSONS	SEVEN PERSONS	EIGHT PERSONS	NINE PERSONS	TEN PERSONS
3031	-	3033									45	151
3034	-	3036									44	150
3037	-	3040									43	149
3041	-	3043									42	148
3044	-	3046									41	147
3047	-	3050									40	146
3051	-	3053									39	145
3054	-	3056									38	144
3057	-	3060									37	143
3061	-	3063									36	142
3064	-	3066									35	141
3067	-	3070									35	140
3071	-	3073									33	139
3074	-	3076									32	138
3077	-	3080									31	137
3081	-	3083									30	136
3084	-	3086									29	135
3087	-	3090									28	134
3091	-	3093									27	133
3094	-	3096									26	132
3097	-	3100									25	131
3101	-	3103									24	130
3104	-	3106*									23	129*
3107	-	3110									22	128
3111	-	3113									21	127
3114	-	3116									20	126
3117	-	3120									19	125
3121	-	3123									18	124
3124	-	3126									17	123
3127	-	3130									16	122
3131	-	3133									15	121
3134	-	3136									14	120
3137	-	3140									13	119
3141	-	3143									12	118
3144	-	3146									11	117

*Net Income Limit

\$3,104

[illegible]

[illegible]

[illegible]

[illegible]

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PART XXIV

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**Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS****GENERAL INFORMATION**

With this application, you can apply for one or more of the following assistance programs. Refer to the fold-out page for instructions.

- Food Stamps
- Temporary Assistance for Needy Families (TANF)
- Medicaid/Children's Health Insurance/FAMIS
- General Relief
- Emergency Assistance
- State and Local Hospitalization
- Auxiliary Grants
- Refugee Resettlement Program

VERIFICATION AND USE OF INFORMATION

The information that you give may be matched against Federal, State and local records including the Virginia Employment Commission and the Department of Motor Vehicles to determine if it is correct, accurate, and truthful. In addition, your Social Security Number (SSN) will be used to verify your identity, prevent receipt of benefits from more than one social service agency at the same time, and make required program changes.

The **INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS)** will also be used to verify information. This system uses your SSN to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration. The State Verification Exchange System (SVES) uses your SSN to verify your receipt of social security and Supplemental Security Income (SSI) benefits. It is also used to verify quarters of coverage under Social Security, if you are an alien. In addition, the Immigration and Naturalization Service (INS) will be used to verify the status of aliens. Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. If a food stamp claim arises against your household, the information on this application, including all SSNs, may be referred to Federal and State agencies, as well as private claims collection agencies, for claims collection action.

032-03-824/16 (6/03)

SPECIAL INFORMATION FOR FOOD STAMP APPLICANTS

You can apply for Food Stamps by leaving a completed Application for Benefits at the agency or by leaving a partially completed Application with at least your name, address, and signature, or by tearing off and leaving this half-sheet with your name, address, and signature. **You must complete the rest of this Application before your eligibility can be determined.**

You must also be interviewed. Under certain hardships, you can be interviewed by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your food stamp amount will be based on the date you actually turn in your application.

EXPEDITED SERVICE FOR FOOD STAMPS

Your household may qualify for Expedited Service and receive food stamps within 7 days if you are eligible and if your gross monthly income is less than \$150 and liquid resources are \$100 or less, or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources, or your household is a migrant or seasonal farm worker household with little or no income and resources. **GIVE THE INFORMATION BELOW, SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Total money expected this month before deductions	\$ _____
Total cash, money in checking/savings accounts, CDs	\$ _____
Total rent or mortgage for this month	\$ _____
Total utility expenses for this month	\$ _____
Do no count amounts due for previous months. Count only the basic telephone service cost.	
Is anyone in your household a migrant or seasonal farm worker	YES () NO ()

NAME	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
	TELEPHONE
SIGNATURE	DATE

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AGENCY USE ONLY		
CASE NAME		
CASE NUMBER		
LOCALITY	WORKER	DATE
EXPEDITED SERVICE DETERMINATION		
<p>Income less than \$150 and Resources \$100 or less</p> <p style="text-align: right;">YES () NO ()</p>		
<p>Income plus resources less than shelter bills</p> <p style="text-align: right;">YES () NO ()</p>		
<p>For migrants or seasonal farm workers:</p> <p>Resources \$100 or less, and in next 10 days \$25 or less is expected from new income:</p> <p style="text-align: center;">OR</p> <p>Resources \$100 or less, and no income is expected from a terminated source for the rest of this month or next month.</p> <p style="text-align: right;">YES () NO ()</p>		
EXPEDITE IF <u>YES</u> TO ANY OF THE ABOVE.		

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may not be able to be determined. Information regarding your race is not required. However, if you decided not to give this information, your worker will complete that section. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

VIRGINIA SOCIAL SERVICES BENEFIT PROGRAMS BOOKLET

This booklet contains information about the programs available at your local social services agency plus other very important information you should know, including your responsibilities. READ THIS BOOKLET CAREFULLY. Refer to the APPEALS Section if you have a complaint about an action taken on your case.

COMPLETING THE APPLICATION

If you need help completing this Application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information neatly and put your initials and date next to the change. If more than 8 people are living in your home and you need more space to list everyone, tell the agency you need extra pages. If you want Medicaid and you are under 18 years of age, your parent or legal guardian must sign the application.

FILING THE APPLICATION

You may turn in a partially completed Application which contains at least your name, address, and signature (or the signature of your authorized representative), but you must complete the rest of this Application before your eligibility can be determined. For some programs, you must also be interviewed, but you may turn in your Application before your interview. You may turn in your Application any time during office hours the same day as you contact your local agency. You have the right to turn in your Application even if it looks like you may not be eligible for benefits.

YOUR FOOD STAMP RIGHTS

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs and disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue SW, Washington D.C. 20250-9410 or call (202) 720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

**VIRGINIA DEPARTMENT
OF SOCIAL SERVICES
APPLICATION FOR BENEFITS**

AGENCY USE ONLY			
CASE NAME	CASE NUMBER	PROGRAM	WORKER CASELOAD
DATE OF SERVICE REFERRAL	DATE OF INTERVIEW	LOCALITY	DATE RECD.

1. I am requesting: () Food Stamps () TANF () Medicaid/Children's Health Insurance/FAMIS () Other Financial or Medical Assistance
() I understand that an application for TANF is also an application for Food Stamps and I do not wish to apply for Food Stamps.

APPLICANT'S NAME	SOCIAL SECURITY NUMBER	PHONE NUMBER (HOME/MESSAGES) (WORK)
RESIDENCE ADDRESS (INCLUDE CITY, STATE AND ZIP CODE)		DIRECTIONS TO HOME
MAILING ADDRESS (IF DIFFERENT)		
LANGUAGE (Enter Code) _____ 1 - English 2 - Spanish 3 - Cambodian 4 - Vietnamese 5 - Farsi 6 - Haitian-Creole 7 - Laotian 8 - Chinese 9 - Korean A - Somali B - Kurdish C - Arabic F - French G - German J - Japanese O - Other		
YES () NO () A. Does anyone have an emergency medical need? If YES, give name and explain _____ YES () NO () B. Is the applicant living in an Assisted Living Facility, an Adult Family Care Home, a Nursing Facility, or other institution? If YES, Date Applicant Entered _____ City/County and State Applicant lived before entering _____ If outside Virginia, was placement made by a government agency? YES () NO () YES () NO () C. ANSWER THIS QUESTION IF APPLYING FOR MEDICAID, GENERAL RELIEF OR AUXILIARY GRANTS: Does this applicant have a spouse who does not live in the home? If YES, Spouse's Name _____ Spouse's Address _____		
2. YES () NO () Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including Food Stamps, AFDC, TANF, Medicaid, General Relief, Auxiliary Grants, Foster Care, Adoption Assistance, or Refugee Cash Assistance? APPLICANT'S NAME _____ SOCIAL SECURITY NUMBER _____ TYPE OF BENEFITS RECEIVED _____ WHEN _____ FROM WHAT COUNTY OR CITY OR STATE _____		

3. YES () NO () Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, Food Stamps, or Medicaid in two or more states at the same time? If YES, give date and place of conviction _____
4. YES () NO () Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If YES, explain _____
5. YES () NO () Have you or anyone for whom you are applying been convicted of a felony for actions that occurred after August 22, 1996, for possession, use or distribution of drugs? If YES, explain _____
6. YES () NO () Is there anything that you would like to talk about with a service worker? This could include concerns about your children, school problems, day care needs, family planning, referrals to other community organizations, or other problems or concerns. If YES, explain _____

INSTRUCTIONS

1. Do not write in the shaded areas. These areas are for agency use only.
2. Unfold this page. Use this folded page to complete **SECTION A: GENERAL INFORMATION**. Answer the questions in **SECTION A** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.
3. Answer the questions in **SECTION B: RESOURCES**, unless you are applying for Children's Health Insurance /FAMIS, for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid** also provide resource information for the following persons:

TANF: Children age 18 or under, even if you are not applying for that child.

Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
 Parents who live with a child under age 21.
 Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.
4. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if applying for **TANF or Medicaid or Children's Health Insurance or FAMIS** also provide income information for the following persons:

TANF: Children age 18 or under, even if you are not applying for that child.

Medicaid: Spouse and children under age 21 who live with a person for whom you are applying.
 Spouse of a person in a nursing facility, state hospital, or community-based care. Provide the spouse's shelter bills to your worker.

Children's Health Insurance/FAMIS Parents and stepparents who live with a child under age 21.
5. After completing Sections A, B, and C, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

<p>Food Stamps</p> <p>TANF/Medicaid</p> <p>Refugee Resettlement Program</p> <p>Children's Health Insurance/FAMIS</p> <p>Medicaid/Auxiliary Grants/General Relief</p> <p>General Relief</p> <p>State and Local Hospitalization</p> <p>Emergency Assistance</p> <p>Auxiliary Grants</p>	<p>Section D pp. 8-9</p> <p>Section E p. 10</p> <p>Section E p. 10 only for children age 18 and under</p> <p>Section F p. 11</p> <p>Section G p. 11</p> <p>Section E p. 10 only for children under age 18 Sections I & J p. 12</p> <p>Section H p. 12</p> <p>Section J. p. 12</p> <p>Section K p. 12</p>
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6. Read **YOUR RESPONSIBILITIES** on page 13.
7. Read and complete **VOTER REGISTRATION** on page 13 of this application.
8. Read and complete the last page of this application. Be sure to sign and date the application.

A. GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. EVERYONE IN YOUR HOME		2. TEMPORARILY AWAY FROM HOME		3. RELATIONSHIP TO PERSON ON LINE #1		4. TYPE OF ASSISTANCE REQUESTED (Check (✓) type of assistance requested for each person. If no assistance is requested, check NONE for that person.)											
<p>LIST EVERYONE LIVING IN YOUR HOME, even if you are not applying for assistance for that person.</p> <p>LIST YOURSELF ON LINE #1.</p> <p>Check (✓) YES () NO () Do you expect any change in who lives in your home, either this month or next month? If YES, explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>LAST NAME, FIRST, MI, AND MAIDEN (DO NOT make any entry in the ID# space)</p>		<p>Is this person temporarily away from home?</p> <p>Check (✓) YES or NO</p> <p>If YES, give the date the person left and expected return date. If more than 45 days, give the reason for the absence.</p> <p>_____</p> <p>_____</p> <p>_____</p>		<p>Give the relationship of each person to the person listed on Line #1.</p> <p>_____</p> <p>_____</p>													
1	YES () NO () Date Left _____ Expected Return Date _____ Reason _____					FOOD STAMPS											
ID#																	
2	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	
3	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	
4	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	
1	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	
6	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	
7	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	
8	YES () NO () Date Left _____ Expected Return Date _____ Reason _____																
ID#																	

Determine reason person is away.

Determine if any parents or spouses live in the home.

Determine if anyone is a payee for anyone else

Determine living arrangement, such as subsidized housing for elderly, hospital, incarceration, etc.

If person is in ALF, nursing facility, state hospital, or CBC, determine if a spouse, dependent, child, or dependent relative is in the home.

Determine living arrangement of the minor parent.

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USE THE FOLDOUT TO COMPLETE THIS SECTION

5. U.S. CITIZEN Check (Y) YES or NO	6. ANSWER ONLY IF AN ALIEN Give the Alien Number and Date of Entry for anyone for whom you are requesting assistance. If YES, do not answer Question 6. You may leave this blank for anyone not in the assistance request.	7. PLACE OF BIRTH Give the State if born in the U.S. or the Country if born outside of the U.S. 8. DATE OF BIRTH	9a. RACE (not required) Give the code from the list at the bottom of the page to show Race.	9b. ETHNICITY (not required) Give the code to show ethnicity: 1 - Hispanic or Latino 2 - Not Hispanic or Latino	10. SEX Give the code to show Sex: M - Male F - Female	11. SOCIAL SECURITY NUMBER Give the number for anyone for whom you are requesting assistance.	12. MARITAL STATUS Give the code to show Marital status: 1 - Married 2 - Never Married 3 - Divorced 4 - Widowed 5 - Separated	13. VETERAN OR DEPENDENT OF A VETERAN Check (Y) YES or NO
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()
YES () NO ()	Alien Number Date of Entry	Place of Birth Date of Birth						YES () NO ()

Race Code List: 1 - White 2 - Black/African-American 3 - American Indian/Alaskan Native 4 - Asian 5 - Native Hawaiian/Other Pacific Islander 6 - American Indian/Alaskan Native and White 7 - Asian and White
8 - Black/African-American and White 9 - American Indian/Alaskan Native and Black/African-American A - Asian and Black B - Other

For Aliens, photocopy INS document. Inquire if requesting emergency care. Determine if sponsored. Obtain sponsor's name address, income, and resources.
For Asylees, verify date asylum was granted.
For Veterans, make referral to V.A.
For Medical Expenses, determine retroactive Medicaid entitlement.

USE THE FOLDOUT TO COMPLETE THIS SECTION

14. MEDICAL EXPENSES DURING THE 3 MONTHS BEFORE THIS MONTH.	15. EDUCATION	16. DISABILITY/PREGNANT STATUS	17. ANSWER ONLY IF DISABLED	18. ANSWER ONLY IF PREGNANT AND APPLYING FOR MEDICAID
Check (✓) YES or NO If YES, give the Date of the Expense.	Give the Last Grade Completed in school. Check (✓) YES or NO Is the person a High School (HS) or GED graduate? Check (✓) YES or NO Is the person Currently Enrolled in school? If YES, give the school name and use one of the codes to show enrollment. FT - Enrolled full time HT - Enrolled half time LT - Enrolled less than half time	Give the code to show Disability/Pregnant Status ND - Not disabled DS - Disabled BL - Blind CD - Needed to care for disabled person PG - Pregnant	A. Check (✓) if the disability reduces or prevents the ability to work or to obtain work. B. Check (✓) if the disability reduces or prevents the ability to care for a child in the home. C. Check (✓) if the disability requires someone to be in the home to provide care.	Give the Conception month and year and the Expected Delivery Date, and the number of Unborn Children.
YES () NO () Date	SCHOOL NAME ENROLLMENT CODE			
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn
YES () NO () Date	A. Last Grade Completed: _____ B. () YES () NO HS or GED Graduate C. () YES () NO Currently Enrolled		A. () Ability to work is reduced B. () Ability to care for child is reduced C. () Someone is needed in the home	Conception Delivery # Unborn

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B. RESOURCES

Answer the resource questions for everyone for whom you are applying unless you are applying for Children's Health Insurance or FAMIS. If applying for TANF or Medicaid, also provide resource information for the additional persons indicated on the INSTRUCTIONS page. Include any resources anyone owns, is currently buying, or is heir to. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the percentage (%) of the resource owned by that person. TALK TO YOUR ELIGIBILITY WORKER IF YOU NEED HELP ANSWERING THESE QUESTIONS, INCLUDING THE PERCENTAGE OWNED.

YES () NO () 1. Cash on hand and not in a bank? If YES, list owner(s) Amount
YES () NO () 2. Checking account, savings or investment account, credit union account, Christmas Club account, CDs or money market account, individual development account, patient funds for people in a nursing facility or Assisted Living Facility, or special welfare fund account? List all accounts, even if there is no money in the account. If Yes to savings or investment account, has the savings account been set up to pay for school expenses, to make a down payment on a house, or to start a business? Check (✓) YES () NO () If the savings account is to pay for school expenses, list the person(s) whose expenses will be paid Amount explain if the savings or investment account is for another purpose.

OWNERS	TYPE OF ACCOUNT	WHERE	YES () NO () Is this resource used in your business or trade, including farming?	AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	YES () NO () Is this resource used in your business or trade, including farming?	\$ AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	YES () NO () Is this resource used in your business or trade, including farming?	\$ AMOUNT	DATE ACQUIRED

OWNERS	TYPE OF ACCOUNT	WHERE	AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED

OWNERS	TYPE OF ACCOUNT	WHERE	AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED

OWNERS	TYPE OF ACCOUNT	WHERE	AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED

OWNERS	TYPE OF ACCOUNT	WHERE	AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED
OWNERS	ACCOUNT #	WHERE	\$ AMOUNT	DATE ACQUIRED

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YES () NO () 7. Licensed or unlicensed vehicles, such as cars, trucks, vans, motorboats, motor homes, mobile homes, recreational vehicles, or motorcycles/mopeds?			
OWNERS	TYPE OF VEHICLE, YEAR-MAKE-MODEL	CURRENTLY LICENSED? YES () NO ()	LICENSE #
	VEHICLE ID#		\$ VALUE \$ AMOUNT OWED
OWNERS	TYPE OF VEHICLE, YEAR-MAKE-MODEL	CURRENTLY LICENSED? YES () NO ()	LICENSE #
	VEHICLE ID#		\$ VALUE \$ AMOUNT OWED
			EXPLAIN HOW VEHICLE IS USED
			DATE ACQUIRED

YES () NO () 8. Health insurance?			
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE	ID NUMBER
		END DATE	\$ PREMIUM AMOUNT
POLICY HOLDER	COMPANY NAME, ADDRESS, PHONE	BEGIN DATE	ID NUMBER
		END DATE	\$ PREMIUM AMOUNT
			TYPE OF COVERAGE
			PERSON(S) INSURED

YES () NO () 9. Medicare?			
PERSON INSURED	CLAIM NUMBER	CHECK () () PART A () PART B	BEGIN DATE
		CHECK () () PART A () PART B	END DATE
PERSON INSURED	CLAIM NUMBER		BEGIN DATE
			END DATE
			PREMIUM
			PAYMENT METHOD

YES () NO () 10. Life insurance policies? (NOT REQUIRED IF YOU ARE APPLYING ONLY FOR FOOD STAMPS)					
OWNERS	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE \$
					CASH VALUE \$
OWNERS	PERSON(S) INSURED	COMPANY NAME, ADDRESS, PHONE	TYPE OF POLICY	POLICY NUMBER	FACE VALUE \$
					CASH VALUE \$
					DATE ACQUIRED

YES () NO () 11. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps?			
In the last 2 years, if applying for TANF or General Relief? Any resources or income in the last 5 years if applying for Medicaid?			
PROPERTY TRANSFERRED	VALUE AT TRANSFER \$	AMOUNT RECEIVED \$	EXPLAIN REASON FOR TRANSFER
FROM WHOM	TO WHOM	DATE ACQUIRED	DATE TRANSFERRED

YES () NO () 12A. Does anyone expect to receive any money because of a legal suit involving personal injury or property damage? If YES, explain.

YES () NO () 12B. Does anyone expect a change in resources this month or next month? If YES, explain and give date change is expected.

EXPLAIN

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C. INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. If applying for TANF or Medicaid, also provide income information for the additional persons indicated on the INSTRUCTIONS page. And for TANF and for Medicaid/Children's Health Insurance/FAMIS for children, also provide income information for the child's parent or stepparent living in the home; or any person living with the parent as husband or wife. If the parent is a minor under age 18 (for TANF) or under age 21 (for Medicaid), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (✓) YES or NO for each type. If YES, give the information requested.

PERSON RECEIVING MONEY FROM WORKING	EMPLOYER'S NAME, ADDRESS, PHONE NUMBER	EMPLOYMENT BEGIN DATE	HOURS WORKED PER MONTH	RATE OF PAY	HOW OFTEN PAID	DAY OF THE WEEK PAID	GROSS MONTHLY PAY BEFORE DEDUCTIONS
YES () NO () Wages/salary	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	Other self employment
YES () NO () Contract income	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	Any other money from working
YES () NO () Commissions, bonuses, tips	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	YES () NO ()	
				\$ PER			\$
				\$ PER			\$
				\$ PER			\$

2. Does anyone receive any other type of money? Check (✓) YES OR NO for each type. If YES, give the information requested.

PERSON RECEIVING MONEY	TYPE OF MONEY RECEIVED	HOW OFTEN RECEIVED	WHEN RECEIVED	GROSS MONTHLY AMOUNT BEFORE DEDUCTIONS
YES () NO () Social Security	YES () NO ()	YES () NO ()	YES () NO ()	Loans
YES () NO () SSI	YES () NO ()	YES () NO ()	YES () NO ()	Training allowances including WIA
YES () NO () VA benefits	YES () NO ()	YES () NO ()	YES () NO ()	Inheritance
YES () NO () Black Lung benefits	YES () NO ()	YES () NO ()	YES () NO ()	All food, clothing, utilities, or rent
YES () NO () Railroad retirement	YES () NO ()	YES () NO ()	YES () NO ()	Any other type of money
YES () NO () Other retirement	YES () NO ()	YES () NO ()	YES () NO ()	

For Self Employment Income, determine expenses.
For Day Care Income, determine whether child lives in the home, number of snacks or meals, expenses.
For Roomer/Boarder Income, determine whether heat is provided, number of meals provided per day.
For Rental Income, determine whether property is actively self-managed, expenses.
For Earned Income, determine whether earnings include EITC advance payments.
Inquire if SSI has been applied for.

For Food Stamps, investigate voluntary quitwork reduction.
For TANF, determine the day care option.
For Medicaid, determine income of spouse, dependent child, or dependent relative of person in nursing facility, state hospital, or CBC.

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YES () NO () 3. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

NAME OF PERSON	EMPLOYER'S NAME, ADDRESS PHONE	EMPLOYED FROM/TO	HRS./WK. WORKED	RATE OF PAY	HOW OFTEN PAID	DATE LAST PAY RECEIVED	REASON FOR LEAVING, REDUCING HOURS
				\$ PER			

YES () NO () 4. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? Or, does anyone totally support food or clothing for you or someone else on a regular basis?

PERSON RECEIVING HELP	PERSON PROVIDING HELP	TYPE OF HELP RECEIVED	AMOUNT	DOES MONEY COME DIRECTLY TO YOU?	IS THIS A LOAN?	IS REPAYMENT EXPECTED
			\$ PER	YES () NO ()	YES () NO ()	YES () NO ()
			\$ PER	YES () NO ()	YES () NO ()	YES () NO ()

YES () NO () 5. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

NAME OF PERSON	TYPE OF FINANCIAL AID	AMOUNT	PERIOD COVERED FROM TO	TUITION FEES	BOOKS/ SUPPLIES	TRANSPOR- TATION	DEPENDENT CARE	ROOM & BOARD	OTHER (specify)
		\$	FROM TO	\$	\$	\$	\$	\$	\$
		\$	FROM TO	\$	\$	\$	\$	\$	\$

YES () NO () 6. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?

If YES, explain and give date: _____

YES () NO () 7. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability?

PERSON PAYING FOR CARE	PERSON RECEIVING CARE	CHECK (X) IF DISABLED	PROVIDER'S NAME, ADDRESS, PHONE NUMBER	AMOUNT PAID
		() Disabled		\$ PER
		() Disabled		\$ PER

YES () NO () 8. Does anyone pay legally obligated child support to someone not in the household? If YES, person paying: _____

Person supported: _____

Amount paid and how often: _____

YES () NO () 9. ANSWER ONLY IF SOMEONE IS APPLYING FOR MEDICAID AND IS BLIND OR DISABLED: Does this person have a work related expense?

If YES, give amount and explain: _____

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D. FOOD STAMPS

1. List the name of the person who is the head of your household: _____

NOTE: Refer to the Benefit Programs Booklet for information about naming the Head of Household.

YES () NO () 2. Would you like to name an authorized representative who could apply for food stamps for you, access your food stamp account to buy food for you, or receive food stamp correspondence and notices for you? You may have only one representative who can access your benefits.

NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)		CHECK (✓) EACH DUTY AUTHORIZED FOR THAT PERSON	
1		() Apply for food stamps () Receive food stamps	() Receive correspondence
2		() Apply for food stamps () Receive food stamps	() Receive correspondence

An authorized representative must have written permission to apply for food stamps. This permission may be given in the space above or in a letter. Only the head of the household, the spouse, or any adult member of the household age 18 or older may give permission for a representative.

YES () NO () 3. Is anyone living in your home NOT included on your Food Stamp application?

If YES, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for Food Stamps is approved? Check (✓) YES () NO () IF YES, list names: _____

YES () NO () 4. Is anyone living in your home a roomer or a boarder? If YES, list names: _____

YES () NO () 5. Is anyone age 60 or older, OR approved to receive Medicaid because of a disability, OR receiving any type of disability check?

If YES, list all current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, psychotherapy, prescription drugs, eye glasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE ANSWERING METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		\$		() Lump sum () Monthly average () Expected payment
		\$		() Lump sum () Monthly average () Expected payment
		\$		() Lump sum () Monthly average () Expected payment

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YES () NO () 6. Does anyone have any shelter expense for rent or mortgage, real estate tax, property tax on a mobile home, home owner's insurance, electricity, gas, kerosene, coal, oil, wood, water or sewer, telephone, or initial installation fee for utilities or telephone? If **YES**, answer question a, b, and c. Then, give the information requested in boxes.

- a. **YES () NO ()** Are any utilities included in your rent? If **Yes**, leave the boxes for those expenses blank.
b. **YES () NO ()** Are taxes or insurance included in your mortgage payment? If **Yes**, leave those boxes blank.
c. **YES () NO ()** Do you have an expense for telephone services? If **Yes**, does anyone living in your home but not included on your Food Stamp application help you pay your telephone bill? Check (✓) **YES ()** or **NO ()**

If **YES**, explain: _____

EXPENSE	Rent or Mortgage	Taxes	Insurance	Electricity	Gas	Kerosene	Coal	Oil	Wood	Water/Sewer	Garbage	Installation
AMOUNT BILLED	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
HOW OFTEN												
WHO PAYS BILL												

YES () NO () 7. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If **YES**, check (✓) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. Actual Utility Expenses () Utility Standard ()

If the **Utility Standard** is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (✓) **YES ()** **NO ()** If **YES**, explain: _____

YES () NO () 8. Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If temporarily staying in someone else's home, give the date you moved in: _____

If **YES**, check (✓) whether you would like your food stamp benefits determined using your actual shelter expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. Actual Shelter Expenses () Homeless Shelter Allowance ()

YES () NO () 9. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from home, illness, or a disaster?

REASON FOR NOT LIVING THERE	DOES PERSON INTEND TO RETURN?	TYPE AND AMOUNT OF SHELTER EXPENSES	IS SOMEONE ELSE LIVING THERE?	IF SOMEONE ELSE LIVES THERE, DOES THAT PERSON PAY RENT?
	YES () NO ()		YES () NO ()	YES () NO ()

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E. FINANCIAL AND MEDICAL ASSISTANCE FOR FAMILIES WITH CHILDREN

(ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

1. CHILD/PARENT INFORMATION		2. PARENT'S STATUS		3. REASONS FOR ABSENCE		4. FINANCIAL SUPPORT		5. PHYSICAL CARE		6. GUIDANCE		7. IMMUNIZATION	
List each child for whom you are applying. Then, list the names of both parents.		Check if either PARENT is:		(Answer only if the answer to question 2 is "absent" and you are applying for Medicaid.) For each ABSENT PARENT, check reason for absence.		Does the ABSENT PARENT regularly provide monthly financial support? Check (✓) YES or NO If YES, give amount, and how often received.		Does the ABSENT PARENT regularly make sure the child eats, sleeps, bathes, dresses properly, and gets proper medical care? Check (✓) YES or NO		Does the ABSENT PARENT regularly participate in the child's activities, attend school conferences, and share in decisions about discipline? Check (✓) YES or NO		(Answer only if applying for TANF and the child is not in school.) Has the child received ALL of the immunizations required according to the child's age? Check (✓) YES or NO or UNKNOWN	
CHILD'S NAME		UNEMPLOYED		PATERNITY NOT ESTABLISHED									YES () NO () UNKNOWN ()
		DISABLED		DIVORCED OR MARRIAGE ANNULLED									
		DEAD		INCAPACITATED									
		ABSENT		DESERTED									
				SEPARATED LIVING APART									
				SENTENCED BY COURT TO DO UNPAID WORK									
				DEPORTED									
				ARTIFICIAL INSEMINATION									
				SINGLE PARENT ADOPTION									
MOTHER							YES () NO () \$ PER		YES () NO ()		YES () NO ()		
FATHER							YES () NO () \$ PER		YES () NO ()		YES () NO ()		
CHILD'S NAME													YES () NO () UNKNOWN ()
MOTHER							YES () NO () \$ PER		YES () NO ()		YES () NO ()		
FATHER							YES () NO () \$ PER		YES () NO ()		YES () NO ()		
CHILD'S NAME													YES () NO () UNKNOWN ()
MOTHER							YES () NO () \$ PER		YES () NO ()		YES () NO ()		
FATHER							YES () NO () \$ PER		YES () NO ()		YES () NO ()		

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F. CHILDREN'S HEALTH INSURANCE/FAMIS

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YES () NO () 1. Did any of the children listed above have health insurance in the past 4 months? If yes, (a) list name of child, type of insurance, such as doctor, hospital, drugs, dental, vision, etc., and the date the insurance ended; and (b) select the reason the insurance ended.

Child: _____ Type of insurance: _____

Date ended: _____

Reason insurance ended:

- ☐ The parent or stepparent changed jobs or stopped employment and no other employer contributes to the cost of family coverage.
- ☐ The parent or stepparent's employer stopped contributing to the cost of family coverage and no other employer contributes to the cost of family coverage.
- ☐ Child uninsurable—insurance company discontinued coverage. (Provide proof that coverage stopped by insurance company)
- ☐ Cost exceeded 10% of monthly income (before taxes). (Provide proof of cost of monthly premium)
- ☐ Stopped/dropped by someone other than parent or stepparent.
- ☐ Stopped/dropped Cobra policy
- ☐ Other _____

YES () NO () 2. Is any member of the family, including a stepparent who lives in the home, employed by a State or Local Government agency? If yes, list name of family member(s) and agency name: _____

YES () NO () 3. Does the employer of any member of the family offer health insurance for family members? If yes, list the names of the children listed on this application who can get insurance through the employer? _____

G. AGED, BLIND OR DISABLED INDIVIDUALS

YES () NO () 1. Have you ever applied for Supplemental Security Income (SSI) or social security as a disabled person? If YES, date applied: _____
Check one: () No Decision Yet () Application Approved () Application Denied

YES () NO () 2. If your application was denied, did you file an appeal of the denial? If yes, explain the action taken by the Social Security Administration (SSA) on the appeal request? _____

YES () NO () 3. Has it been less than 12 months since your most recent application for social security or SSI disability benefits was denied? If yes, list the medical conditions that you asked SSA to evaluate. _____

YES () NO () 4. Has your condition changed or worsened since your most recent application for social security or SSI disability benefits was denied. If yes, explain how your condition has changed or worsened. _____

YES () NO () 5. Do you have a new condition that has occurred since your most recent application for social security or SSI disability benefits was denied? If yes, explain the new condition. _____

YES () NO () 6. Did you receive an Auxiliary/Grants check that has stopped? If yes, explain when and why the payments stopped. _____

YES () NO () 7. Did you receive a SSI check that has stopped? If yes, explain when and why the payments stopped. _____

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H. STATE AND LOCAL HOSPITALIZATION

YES () NO () Have you received or will you be receiving in-patient/out-patient hospitalization services, or ambulatory surgical services, or services through a health department clinic? If YES, please fill out the following:

PERSON RECEIVING SERVICES	NAME OF HOSPITAL OR CLINIC	IF SERVICE HAS ALREADY BEEN RECEIVED, GIVE THE DATES BELOW DATE ADMITTED: DATE DISCHARGED:
---------------------------	----------------------------	---

If you were hospitalized as the result of an accident, complete the following:

WHAT HAPPENED, WHERE, HOW	NAME, ADDRESS OR PERSON AT FAULT	IS A LIABILITY SUIT PLANNED OR IN PROGRESS? YES () NO ()
NAME, ADDRESS OF ALL INSURANCE COMPANIES INVOLVED	NAME, ADDRESS, PHONE NUMBER OF YOUR ATTORNEY	

I. GENERAL RELIEF

YES () NO () Does anyone have any responsibility for rent or utility bills (not telephone), even if someone else helps pays?

J. GENERAL RELIEF/EMERGENCY ASSISTANCE

YES () NO () Does anyone have any emergency food, rent, utility (not deposits), medical, clothing, transient or relocation expenses?

DESCRIPTION AND CAUSE OF EMERGENCY

K. AUXILIARY GRANTS

YES () NO () 1. Do you own any household goods or personal effects which are worth more than \$500, such as silver, fine china, furs, artworks, expensive jewelry, or other expensive items?

DESCRIPTION AND VALUE OF ITEMS

YES () NO () 2. Do you owe or did you pay in the month or application any bills you had before you entered the assisted living facility or adult family care?

DESCRIPTION OF BILLS	DATES OF BILLS	DATES BILLS PAID
----------------------	----------------	------------------

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YOUR RESPONSIBILITIES (READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)**CHANGES**

You must report the following changes for the Medicaid Program within 10 days. You must report these changes for the Auxiliary Grants and General Relief Programs the day the change occurs or the first day that the agency is open after the change occurs. The following examples of changes may include some that do not have to be reported for every program. If you are not sure whether to report a particular change, please discuss the change with your worker.

- 1) Change of address and any changes in shelter costs due to the move
 - 2) Change in the persons in the household – person left, person born, etc.
 - 3) Change in source of income, getting a new job, stopping a job, other benefits, etc.
 - 4) Change in work hours from part-time to full-time or full-time to part-time
 - 5) Change in rate of pay per hour/day, etc.
 - 6) Change in the amount of monthly income received other than from a job.
 - 7) Change in resources
 - 8) Change in motor vehicles owned
 - 9) Change in marital status
 - 10) Person in home is no longer disabled
 - 11) Change in dependent care expenses
 - 12) Other changes that may affect eligibility for a program or the amount of assistance
- You must report the following changes for the Food Stamp and Temporary Assistance for Needy Families (TANF) Programs within 10 days.
- 1) Change in household income that exceeds 130% of the Federal poverty level. See the Change Report for amounts.
 - 2) Change in address.

- 3) Changes needed for VIEW (TANF work program).
- 4) Change in work hours for some food stamp recipients.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell EBT cards. You must not use food stamp benefits to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's, EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); subject to \$250,000 fine, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information or hides information about identity or residence to get food stamps in more than one locality at the same time could be barred for 10 years.

Anyone court convicted of trading or selling food stamps of \$500.00 or more could be barred permanently.

Anyone court convicted of trading food stamps for a controlled substance could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

Anyone court convicted of trading food stamps for firearms, ammunition, or explosives could be barred permanently for the first violation.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, Food Stamps or SSI in two or more states in ineligible for TANF for 10 years.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

**INFORMATION ABOUT THE DIVISION OF CHILD
SUPPORT ENFORCEMENT (DCSE)**

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to DCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights.

VOTER REGISTRATION

Check one of the following:

- () I am not registered to vote where I currently live now, and would you like to register to vote here today. I certify that a voter registration application form was given to me to complete. (If you would like help filling out the voter registration application form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.)
- () I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
- () I do not want to apply to register to vote today.
- () I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497, (804) 786-6551.

Agency Use Only: ☐ Face-to-face interview not required. A voter registration form was mailed.

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BY MY SIGNATURE BELOW, I DECLARE:

- I understand all other information in the GENERAL INFORMATION and the YOUR RESPONSIBILITIES sections of this application.
- I understand that if I refuse to cooperate with any review of my eligibility including review by Quality Control, my benefits may be denied until I cooperate.
- I understand that if my application is for Food Stamps, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.
- I understand that Medicaid, FAMIS, and DMAS contractors may exchange information relating to my child(ren)'s coverage with local educational agencies, to assist with application, enrollment, administration, and billing for services provided to my child in schools. I understand that I can revoke the consent to disclose information at any time.
- I understand that to receive benefits from the Medicaid/Children's Health Insurance/FAMIS programs, I must agree to assign my rights and the rights of anyone for whom I am applying to medical support and other third-party payments to the Department of Medical Assistance Services. If I do not agree to assign my rights, I will be ineligible for Medicaid.
- I understand that all money I receive for diagnosis or treatment of any injury, disease, disability, or medical care support must be sent to the Third-Party Liability Section, Department of Medical Assistance Services, Suite 1300, 600 East Broad Street, Richmond, VA 23219.
- I understand that I have the right to file a complaint if I feel I have been discriminated against because of race, color, national origin, sex, age, handicap, or religious belief.
- I understand that if I am applying for Medicaid/Children's Health Insurance/FAMIS for my children, I can apply for and receive services from the Division of Child Support Enforcement, but failure to apply for the services will not affect my child(ren)'s eligibility. If I am applying for Medicaid, failure to cooperate my cause my ineligibility for Medicaid.
- I understand that I have the right to appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application within specified time frames; (2) denied benefits from the programs for which I applied; or (3) dissatisfied with any other decision that affects my receipt of Medicaid/Children's Health Insurance. For FAMIS, there will be no opportunity for review of a negative action if the sole basis for the action is exhaustion of funding.
- I will report any changes in my situation within the time frames specified on page 13 to my local department of social services.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- I understand that my signature on this application certifies, under penalty of perjury, that I am (unless applying for emergency services only) a U.S. Citizen or alien in lawful immigration status.
- I authorize the Department of Social Services and the Department of Medical Assistance Services to obtain any verification necessary to both determine and review financial or medical assistance eligibility. This authorization includes the release of any medical or psychological information obtained from any source to any state or local agency that may review this application and the release to the Department of Medical Assistance Services of any information in any medical records pertaining to any services received by me or anyone for whom I applied. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I received the Benefit Programs Booklet YES () NO () MEDICAID APPLICANTS: I received the Medicaid Handbook YES () NO ()

TANF APPLICANTS:

The diversionary assistance program was explained to me. YES () NO ()
The family cap provision was explained to me. YES () NO ()

I filled in this application myself. YES () NO () If NO, it was read back to me when completed. YES () NO ()

APPLICANT'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK	DATE	SPOUSE'S OR AUTHORIZED REPRESENTATIVE'S SIGNATURE OR MARK (NOT NEEDED FOR FOOD STAMPS)	DATE
WITNESS TO MARK OR INTERPRETER	DATE	WORKER'S SIGNATURE	DATE

Complete the box below if this application was completed for the applicant by someone else.

NAME OF PERSON COMPLETING APPLICATION	DATE	ADDRESS
PHONE NUMBER (HOME)	(WORK)	RELATIONSHIP TO APPLICANT

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Commonwealth of Virginia
Department of Social Services

EVALUATION OF ELIGIBILITY

1. GENERAL INFORMATION

1. GENERAL INFORMATION		PROGRAM	APPLICATION DATE	INTERVIEW DATE
CASE NAME	CASE NUMBER			
SECONDARY CASE NAME	SECONDARY CASE NUMBER			
IDENTITY (NAME)	VERIFICATION			
HEAD OF HOUSEHOLD ADULT PARENT/PARENTAL CONTROL? <input type="checkbox"/> Y <input type="checkbox"/> N DESIGNATED BY HH <input type="checkbox"/> AGENCY <input type="checkbox"/>		FACE-TO-FACE INTERVIEW? <input type="checkbox"/> Y <input type="checkbox"/> N IF NO, REASON:		
ADDRESS	SECONDARY ADDRESS, TYPE	INSTITUTIONAL STATUS Date Entered <input type="checkbox"/> NF <input type="checkbox"/> CBC <input type="checkbox"/> ACR		
VERIFICATION/REMARKS	VIRGINIA RESIDENT? <input type="checkbox"/> Y <input type="checkbox"/> N	ACR/AFC RATE:	DMAS-96 <input type="checkbox"/> Y <input type="checkbox"/> N	SAR <input type="checkbox"/> Y <input type="checkbox"/> N

2. MEMBER INFORMATION

NAME OR MBR#	HH/UNIT MEMBERSHIP CHECK (✓) IF INCLUDED						PERMANENT VERIFICATIONS CHECK (✓) IF REQ. MET				FSET/ESP/VIEW REGISTRATION OR REFERRAL	ATTENDING SCHOOL?	DEPRIVATION (MED - ONLY EFF 7/1/99)	IMMUNIZATION REQUIREMENT MET?
	FS	TANF	MED	AG	MEDICAID/AG CATEGORY	OTHER (LIST)	SSN	DOB	CIT	REL				
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
											<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

NAME	PROGRAM	REASON FOR EXCLUSION, DISQUALIFICATION OR INELIGIBILITY	TIME PERIOD

ASSIGNMENT OF RIGHTS? <input type="checkbox"/> Y <input type="checkbox"/> N	NOTICE OF COOPERATION AND GOOD CAUSE SIGNED? <input type="checkbox"/> Y <input type="checkbox"/> N	GOOD CAUSE CLAIMED? <input type="checkbox"/> Y <input type="checkbox"/> N	LIVING WITH SPECIFIED RELATIVE/GUARDIAN <input type="checkbox"/> Y <input type="checkbox"/> N
--	--	---	---

DEPRIVATION, TRUANCY, PREGNANCY, CONCEPTION/DELIVERY DATE, FOSTER CARE/ADOPTION STATUS, DISABILITY/BLINDNESS OR OTHER DOCUMENTATION

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RETROACTIVE DETERMINATION NECESSARY ? <input type="checkbox"/> Y <input type="checkbox"/> N RETROACTIVE PERIOD _____	POTENTIALLY PROTECTED MEMBERS PROTECTED MEMBERS (INCLUDED STATUS)	COMMUNITY SPOUSE? <input type="checkbox"/> Y <input type="checkbox"/> N
---	--	--

CASH	<input type="checkbox"/> Y <input type="checkbox"/> N	ACCOUNTS	<input type="checkbox"/> Y <input type="checkbox"/> N	STOCKS/BONDS	<input type="checkbox"/> Y <input type="checkbox"/> N	PENSION PLANS	<input type="checkbox"/> Y <input type="checkbox"/> N	PROGRAM(S)
				TRUST FUNDS		RETIREMENT		

PROMISSORY NOTES/DEEDS OF TRUST ☐ Y ☐ N BURIAL ☐ Y ☐ N PERSONAL PROPERTY ☐ Y ☐ N REAL PROPERTY ☐ Y ☐ N
PROGRAM(S)

VEHICLES ☐ Y ☐ N DMV ☐ MATCH ☐ NO MATCH DATE _____ PROGRAM(S) _____

HEALTH INSURANCE ☐ Y ☐ N MEDICAID: HIPPA APPLICATION, MEDICAL QUESTIONNAIRE COMPLETED ☐ Y ☐ N

MBR	TYPE	COMPANY	POLICY ID#	VERIFICATION	PREMIUM

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LIFE INSURANCE ☐ Y ☐ N (NOT APPLICABLE FOR FOOD STAMPS)

MBR	OWNER	TYPE	FACE \$	CASH \$	COMPANY, ACCT#	VERIFICATION	PROGRAM(S)		

COUNTABLE

6. TRANSFER OF RESOURCES ☐ Y ☐ N (MEDICAID: ALSO EVALUATE TRANSFER OF INCOME)

MBR	TYPE, DATE	VALUE	AMOUNT	VERIFICATION, CALCULATION OF PERIOD OF INELIGIBILITY	
					FS
					TANF
					MED

7. EARNED INCOME ☐ Y ☐ N

PROGRAM(S)

MBR	INCOME SOURCE	DATE REC'D	AMOUNT	FREQUENCY	HRS/WK	VERIFICATION	PROGRAM(S)		

COUNTABLE

8. UNEARNED INCOME ☐ Y ☐ N

PROGRAM(S)

MBR	INCOME SOURCE	DATE REC'D	AMOUNT	FREQUENCY	VERIFICATION	PROGRAM(S)		

COUNTABLE

VEC ☐ Match ☐ No Match Date _____ SVES ☐ Match ☐ No Match Date _____ APCS ☐ Match ☐ No Match Date _____

CALCULATIONS (DOCUMENT DISREGARDS, INCOME SCREENINGS, SELF EMPLOYMENT EXPENSES, SCHOOL EXPENSES, CHILD SUPPORT)

APPLICATION FOR OTHER BENEFITS: () SSA () SSI () UCB () VA () OTHER _____

TOTAL COUNTABLE RESOURCES			
FS	TANF	MEDICAID	
\$	\$	\$	\$

TOTAL COUNTABLE INCOME			
FS	TANF	MEDICAID	
\$	\$	\$	\$

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9. EXPENSES**SHELTER EXPENSES** ☐ Y ☐ N

TYPE OF EXPENSE	MO. AMT.	VERIFICATION
RENT/MORTGAGE		
ELECTRICITY		
GAS/KEROSENE/COAL OIL/ WOOD		
WATER/SEWER		
GARBAGE		
INSTALLATION		
TAX/INSURANCE		

DAY CARE EXPENSES ☐ Y ☐ N **CHILD SUPPORT DEDUCTION** ☐ Y ☐ N

MBR	MO. AMT.	DESCRIPTION, VERIFICATION

MEDICAL EXPENSES ☐ Y ☐ N

MBR	MO. AMT.	DESCRIPTION, VERIFICATION, METHOD OF DEDUCTION

UTILITY STANDARD ☐ Y ☐ N ☐ 1-3 ☐ 4+ PHONE STANDARD ☐ Y ☐ N HOMELESS STANDARD ☐ Y ☐ N

REASON FOR ENTITLEMENT TO STANDARD:

10. GENERAL RELIEF (MAINTENANCE)

Period of Unemployment: _____

Applied for SSI ☐ Decision appealed ☐

Release of SSI check signed: _____

Modified Standard ☐ Full Standard ☐

Reason for Standard: _____

11. EMERGENCY ASSISTANCE () GR () TANF-EA

Date and Reason for Emergency: _____

Assistance Previously Received? ☐ Y ☐ N

Date and Amount Received: _____

12. STATE AND LOCAL HOSPITALIZATION

MBR	Service Dates	Provider Name	Applied within 30 days? <input type="checkbox"/> Y <input type="checkbox"/> N

13. DIVERSIONARY ASSISTANCE PROGRAM

Loss/Delay of Income <input type="checkbox"/> Y <input type="checkbox"/> N TANF Requirements Met? <input type="checkbox"/> Y <input type="checkbox"/> N	EVALUATION:
Emergency Need \$ _____ Type _____	
TANF \$ _____ Payment \$ _____ Date Issued _____ (Max 4 months)	
Vendor Payment Issued to: _____	
TANF Period of Ineligibility: _____ to _____	
Diversionsary Assistance Ineligibility (60 mos.) Ends: _____	
Acceptance Signed: <input type="checkbox"/> Y <input type="checkbox"/> N Date: _____	

14. SPEND-DOWN CALCULATION

COUNTABLE INCOME \$ _____ \$ _____ \$ _____	SPEND-DOWN PERIOD: _____ FROM _____ TO _____
MINUS INCOME LEVEL _____	Person(s) on Spend-down: _____
EXCESS INCOME _____	Person(s) on Spend-down: _____

15. DISPOSITIONTEMPORARY ASSISTANCE PROGRAMS
DATE GIVEN: BOOKLET _____FOOD STAMPS
HOTLINE _____MEDICAID
HANDBOOK _____

PROGRAM	DISPOSITION (Denial Reason)	EFFECTIVE DATE/ CERT/COVERED PERIOD	HH/AU SIZE	MONTHLY BENEFITS	PRORATED BENEFITS	SIGNATURE AND DATE (WORKER/SUPERVISOR)

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

FOOD STAMP PROGRAM – HOTLINE INFORMATION

NAME OF APPLICANT: _____

YOUR DATE OF APPLICATION: _____

**THE DATE THE AGENCY MUST GIVE YOU
YOUR FOOD STAMPS OR A DECISION:** _____

☐ IF THIS BOX IS CHECKED, YOUR APPLICATION IS ENTITLED TO EXPEDITED SERVICE
(7-DAY SERVICE)

If you don't get your food stamps or a decision by this date, you should call the Client Services Hotline for immediate help. The Hotline is open Monday through Friday, except holidays, from 8:15 a.m. to 5:00 p.m. The numbers are:

For the Richmond Calling Area: **692-2198**

For the Rest of Virginia: **1-800-552-3431**

Once you have called this number, you must be told by the next business day that you are either eligible or ineligible. If you are told that you are eligible, food stamps will be provided the next business day. However, if you call before 3:00 p.m. on Thursday or Friday and are eligible, food stamps will be provided on the next business day.

If you are not satisfied with the action the local agency took on your application, or if there are other problems with your Food Stamp case, you may contact the local legal aid office in your area. Names and addresses of legal aid offices are on the back of this flyer.

In order to determine if you are eligible for Food Stamps, the agency may ask you to verify certain information. If you have provided the required verifications, you should either have your food stamps or receive a denial notice within 30 days from the day you filed your application.

If you are in an emergency situation, you should have your food stamps within 7 days. This is called "expedited service." Your application will be given expedited service if:

- Your household's monthly income is less than \$150, and resources are \$100 or less; or
- Total income and resources are less than your shelter bills; or
- A migrant or seasonal farm worker lives in your household, and you have little or no income or resources.

NAME OF WORKER COMPLETING THIS FORM

WORKER'S TELEPHONE

032-03-819/8 (08/03)

The Virginia Department of Social Services is an Equal Opportunity Provider

Blue Ridge Legal Services, Inc.
204 North High Street
Harrisonburg VA
(540) 433-1830
1-800-237-0141

Blue Ridge Legal Services, Inc.
119 South Kent Street
Winchester VA
540-662-5021
1-800-678-5021

Blue Ridge Legal Services, Inc.
203 North Main Street
Lexington VA
540-463-7334

Blue Ridge Legal Services, Inc.
132 Campbell Avenue, SW
Suite 300
Roanoke VA
540-344-2088
1-866-534-5243

Central VA Legal Aid Society
101 West Broad Street, Suite 101
Richmond VA
804-648-1012

Central VA Legal Aid Society
617 W. Main Street, 2nd Floor
Charlottesville VA
(434) 296-8851
1-800-390-9983

Central VA Legal Aid Society
10-A Bollingbrook
Petersburg VA
804-862-1100

Eastern VA Legal Aid Society
125 St. Paul's Boulevard
Norfolk VA
757-627-5423
1-800-868-1072

Legal Aid Justice Center
1000 Preston Avenue, Suite A
Charlottesville VA
(434) 977-0553
1-800-578-8111

Legal Aid Society of Roanoke Valley
416 Campbell Avenue SW
Roanoke VA
(540) 344-2088
1-800-711-0617

Legal Services of Eastern VA
2017 Cunningham Dr. Suite 300
Hampton VA
757-827-2912
1-800-944-6624

Legal Services of Eastern VA
199 Armistead Avenue
Williamsburg VA
757-220-6837
1-800-455-8208

Legal Services of Eastern VA
36314 Lankford Highway, Suite 5
Belle Haven VA
757-442-3014
1-800-455-8208

Legal Services of Northern VA
6400 Arlington Boulevard
Suite 630
Falls Church VA
703-532-3733

Legal Services of Northern VA
603 King Street, 4th Floor
Alexandria VA
703-684-5566

Legal Services of Northern VA
1916 Wilson Boulevard, Suite 200
Arlington VA
(703) 532-3733

Legal Services of Northern VA
4080 Chain Bridge Road
Fairfax VA
703-246-4500

Legal Services of Northern VA
204 Wirt Street, SW
Leesburg VA
703-777-7450

Legal Services of Northern VA
9240 Center Street
Manassas VA
703-368-5711

Rappahannock Legal Services, Inc.
910 Princess Anne Street
Fredericksburg VA
540-371-1105

Rappahannock Legal Services, Inc.
314 North West Street
Culpeper VA
540-825-3131

Rappahannock Legal Services, Inc.
P.O. Box 1662
Tappahannock VA
(804) 443-9393
1-800-572-3094

Southwest VA Legal Aid Society, Inc.
155 Arrowhead Trail
Christiansburg VA
540-382-6157
1-800-468-1366

Southwest VA Legal Aid Society, Inc.
227 West Cherry Street
Marion VA
(276) 783-8300
1-800-277-6754

Southwest VA Legal Aid Society, Inc.
P.O. Box 670
Castlewood VA
(276) 762-9356
1-888-201-2772

Virginia Legal Aid Society
513 Church Street
Lynchburg VA
804-528-4722
1-800-552-7676

Virginia Legal Aid Society
105 S. Union Street, Suite 400
Danville VA
804-799-3550
1-800-552-7676

Virginia Legal Aid Society, Inc.
104 High Street
Farmville VA
804-392-8108
1-800-552-7676

Virginia Legal Aid Society, Inc.
112 W. Washington Street, Suite 300
Suffolk VA
757-539-3441
1-800-552-7676

Virginia Legal Aid Society, Inc.
412 South Main Street
Emporia VA
804-634-5172
1-800-552-7676

Legal Aid Justice Center
1000 Preston Avenue, Suite A
Charlottesville VA
(434) 296-8851
1-800-200-8479

Legal Services Corp. of Virginia
700 E. Main Street, Suite 1504
Richmond, VA
(804) 782-9438

Virginia Poverty Law Center, Inc.
201 W. Broad Street, Suite 302
Richmond, VA
(804) 782-9430
1-800-868-8752

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

ADVANCE NOTICE OF PROPOSED ACTION

CASE NUMBER	PROGRAM

DATE OF MAILING: _____

IF YOU WANT FREE LEGAL ADVICE, CALL: _____
THIS NUMBER IS A LOCAL LEGAL SERVICES AGENCY, NOT
THE DEPT. OF SOCIAL SERVICES.

ACTION TO BE TAKEN ON YOUR CASE IS EXPLAINED BELOW.

<input type="checkbox"/> FOOD STAMPS			
YOUR FOOD STAMP ALLOTMENT WILL BE: <input type="checkbox"/> REDUCED <input type="checkbox"/> SUSPENDED <input type="checkbox"/> TERMINATED			
EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:
REASON FOR PROPOSED ACTION: _____			

<input type="checkbox"/> FINANCIAL ASSISTANCE			
YOUR ASSISTANCE CHECK WILL BE: <input type="checkbox"/> REDUCED <input type="checkbox"/> SUSPENDED <input type="checkbox"/> TERMINATED			
EFFECTIVE DATE:	AMOUNT OF REDUCTION: FROM: TO:	ELIGIBILITY WORKER:	TELEPHONE:
MANUAL REFERENCE: _____ REASON FOR PROPOSED ACTION: _____			
<input type="checkbox"/> VIEW TERMINATION - THE TANF CASE IS CLOSED UNTIL YOU REAPPLY AND ARE FOUND ELIGIBLE FOR TANF/TANF-UP			
<input type="checkbox"/> VIEW SANCTION - YOUR HOUSEHOLD'S ENTIRE TANF OR TANF-UP BENEFITS WILL BE SUSPENDED FOR THE ABOVE REASON.			
<input type="checkbox"/> 1 ST SANCTION - 1 MONTH OR COMPLIANCE <input type="checkbox"/> 2 ND SANCTION - 3 MONTHS AND COMPLIANCE <input type="checkbox"/> 3 RD SANCTION - 6 MONTHS AND COMPLIANCE			
YOU HAVE 10 DAYS AFTER THE DATE OF THIS NOTICE TO CONTACT YOUR VIEW WORKER TO SHOW DOCUMENTED GOOD CAUSE.			
VIEW WORKER'S NAME _____ TELEPHONE: _____			
<input type="checkbox"/> WHILE YOUR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PAYMENT IS SUSPENDED, ANY SUPPORT PAID TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT FOR YOU OR YOUR DEPENDENTS WILL BE KEPT BY THE STATE TO REPAY THE PAST TANF ASSISTANCE RECEIVED BY YOUR FAMILY. IF YOUR TANF DEBT HAS BEEN FULLY REPAID, YOU WILL RECEIVE THE SUPPORT COLLECTED.			
<input type="checkbox"/> IF THERE IS SOMEONE WHO IS SUPPOSED TO PAY SUPPORT FOR YOU OR YOUR DEPENDENTS, YOU WILL CONTINUE TO RECEIVE SUPPORT ENFORCEMENT SERVICES UNLESS YOU SEND WRITTEN NOTICE THAT YOU DO NOT WANT THIS SERVICE TO THE DIVISION OF CHILD SUPPORT ENFORCEMENT. YOU CAN OBTAIN THEIR ADDRESS AND TELEPHONE NUMBER FROM YOUR LOCAL SOCIAL SERVICES AGENCY.			
<input type="checkbox"/> IF YOU RECEIVE A LUMP SUM PAYMENT IN THE MONTH ACTION IS TAKEN TO CLOSE YOUR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES CASE. YOU MUST REPORT RECEIPT OF THE LUMP SUM TO YOUR ELIGIBILITY WORKER.			

<input type="checkbox"/> MEDICAID OR STATE/LOCAL HOSPITALIZATION (SLH)			
<input type="checkbox"/> NO LONGER ELIGIBLE FOR FULL MEDICAID. APPROVED FOR LIMITED MEDICAID COVERAGE: QMB _____ SLMB _____ QI1 _____			
<input type="checkbox"/> NO LONGER ELIGIBLE FOR MEDICAID. <input type="checkbox"/> NO LONGER ELIGIBLE FOR PAYMENT OF LONG-TERM CARE BECAUSE OF TRANSFER OF ASSETS.			
<input type="checkbox"/> NO LONGER ELIGIBLE FOR SLH.			
EFFECTIVE DATE:	MANUAL REFERENCE:	ELIGIBILITY WORKER:	TELEPHONE:
INELIGIBLE FAMILY MEMBERS: _____			
REASON FOR PROPOSED ACTION:			
<input type="checkbox"/> INCOME EXCEEDS THE FULL MEDICAID LIMIT. IF MEDICAL OR DENTAL EXPENSES OF \$ _____ ARE INCURRED BETWEEN _____ AND _____ OR MEDICAL OR DENTAL EXPENSES OF \$ _____ ARE INCURRED BETWEEN _____ AND _____, BRING YOUR BILLS TO THIS AGENCY AND YOUR ELIGIBILITY WILL BE REVIEWED.			
<input type="checkbox"/> OTHER: _____			

IF YOU DISAGREE WITH THE PROPOSED ACTION, YOU MAY WRITE OR CALL YOUR WORKER AND ASK FOR A CONFERENCE, OR YOU MAY REQUEST IN WRITING A FAIR HEARING TO APPEAL THE ACTION. AT THE HEARING, YOU WILL HAVE A CHANCE TO EXPLAIN WHY YOU THINK WE MADE A MISTAKE AND A HEARING OFFICER OR APPROPRIATE AUTHORITY WILL DECIDE IF YOU ARE RIGHT. SEE ADDRESSES AND INSTRUCTIONS ON BACK FOR FILING APPEALS.

IF YOU APPEAL THE PROPOSED ACTION ON YOUR GENERAL RELIEF, AUXILIARY GRANT, OR FOOD STAMP CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF YOU APPEAL THE PROPOSED ACTION ON YOUR TANF/VIEW, REFUGEE RESETTLEMENT, MEDICAID OR SLH CASE BEFORE _____, ASSISTANCE MAY CONTINUE. IF THE HEARING DECISION SUPPORTS THE ACTION BEING PROPOSED BY THE AGENCY, YOU MAY HAVE TO REPAY ASSISTANCE YOU RECEIVED DURING THE APPEAL PROCESS. YOU MAY WAIVE YOUR RIGHT TO CONTINUED ASSISTANCE BY SUBMITTING A WRITTEN STATEMENT TO YOUR ELIGIBILITY WORKER INDICATING YOUR DESIRE TO REFUSE SUCH ASSISTANCE. AN APPEAL CAN BE FILED FOR GENERAL RELIEF AND AUXILIARY GRANT CASES, FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE AND FOR FOOD STAMPS FOR UP TO 90 DAYS. FOR TANF/VIEW, REFUGEE ASSISTANCE, MEDICAID, AND SLH, AN APPEAL CAN BE FILED FOR UP TO 30 DAYS AFTER RECEIPT OF THIS NOTICE IF THE PROPOSED ACTION IS EFFECTIVE WITHIN THE NEXT 30 DAYS. IF THE PROPOSED ACTION IS EFFECTIVE MORE THAN 30 DAYS FOLLOWING RECEIPT OF THIS NOTICE, AN APPEAL MAY BE FILED UNTIL THE EFFECTIVE DATE.

NOTE: FOR ADDITIONAL INFORMATION ABOUT APPEALS AND FAIR HEARINGS, REFER TO THE BACK OF THIS FORM.

032-03-018/25 (5-03)

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APPEALS AND FAIR HEARINGS

SEND WRITTEN APPEALS TO THE ADDRESSES BELOW. YOU MAY ALSO FILE A FOOD STAMP APPEAL ORALLY BY CALLING YOUR LOCAL AGENCY OR DIALING TOLL FREE 1-800-552-3431.

FINANCIAL ASSISTANCE
AND FOOD STAMP
APPEALS SHOULD BE
SENT TO:

HEARINGS AND LEGAL SERVICES MANAGER
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
730 EAST BROAD STREET
RICHMOND, VA 23219-1849

MEDICAID AND SLH
APPEALS SHOULD BE
SENT TO:

CLIENT APPEAL DIVISION
DEPARTMENT OF MEDICAL
ASSISTANCE SERVICES
600 EAST BROAD STREET,
SUITE 1300
RICHMOND, VA 23219

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for money payments, Medicaid, SLH, and/or food stamps. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearings officer is the official representative of the State Department of Social Services or the Department of Medical Assistance Services.

In addition to filing an appeal, you have the right to request a conference with your local social services agency, at which time the agency must give you an explanation of its proposed action. You must also be given the opportunity to present any information on which your disagreement with the agency's proposed action is based. At such a conference, you have the right to have your story presented by an authorized representative, such as a friend, relative or lawyer.

If you request the conference within 10 days of receipt of your Advance Notice of Proposed Action to decrease or terminate your services, money payments or food stamps, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the local social services agency's action following the conference, and you want to request that your money payments be continued as usual until a hearing decision is received, you must file an appeal within two days following the date of the conference. You must request the appeal within 10 days of the conference date for Food Stamps. If you do not request a conference but file your appeal within 10 days of your advance notice of action to reduce, suspend, or terminate your services, money payments or food stamps, your benefits may be continued until a hearing decision is reached. If you appeal the proposed action on your TANF/VIEW, Refugee Assistance, or Medicaid case prior to the reduction, suspension, or termination effective date, you may also receive continued coverage. However, if the agency action is upheld, you will be required to repay assistance received during the appeal process.

If you request an appeal concerning food stamps, the local social services agency must offer you a conference after your appeal is filed.

If you wish to request a hearing, follow the instructions on the front of this form.

The person who conducts the hearing is someone from the State Department of Social Services or the Department of Medical Assistance Services, not someone from your local social services agency. The hearings officer makes a decision on your appeal.

You will be notified of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your service or eligibility worker immediately. If you need transportation, the local agency will provide it. You may bring a representative and/or witnesses to the hearing to help you tell your story. Your service or eligibility worker, a local agency supervisor and possibly other agency staff who know about your case may also be at the hearing to tell how the agency's decision was reached.

At the hearing, you and/or your representative will have the opportunity to:

- (1) Examine all documents and records that are used at the hearing;
- (2) Present your case or have it presented by a lawyer or by another authorized representative;
- (3) Bring witnesses;
- (4) Establish pertinent facts and advance arguments; and
- (5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision of the hearings officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearings officer's decision on your appeal within 60 days of the date your appeal request is received by the State Department of Social Services. If the decision is based on a Medicaid or SLH appeal, you will be notified in writing within 90 days of the date your appeal is received by the Department of Medical Assistance Services.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES**CHANGE REPORT**

CASE NAME	CASE NUMBER
WORKER NAME	LOCALITY
AGENCY TELEPHONE NUMBER	

You must report the changes listed below for your Food Stamps or Temporary Assistance for Needy Families (TANF) case.

Report changes within 10 days of the day they occur; but at the latest, you have until the 10th day of the following month to report the change.

ADDRESS CHANGE

New Address (Street, Apt. Number)	City, State Zip	Telephone
-----------------------------------	-----------------	-----------

INCOME FOR YOUR HOUSEHOLD GOES OVER THE LIMIT BELOW

Number of People in your Household	Gross Income Limits			
	Monthly	Weekly	Every 2 weeks	Twice a month
1	\$ 973	\$ 226.28	\$ 452.56	\$ 486.50
2	1,313	305.35	610.70	656.50
3	1,654	384.65	769.30	827.00
4	1,994	463.73	927.45	997.00
5	2,334	542.80	1,085.59	1,167.00
6	2,674	621.87	1,243.73	1,337.50
7	3,014	700.94	1,401.87	1,507.00
8	3,354	780.00	1,560.00	1,677.00
For each additional member add	+ \$341	+ \$79.31	+ \$158.61	+ \$170.50

These amounts are good through 9/30/04.

Add gross income for all the people in your household. New income total \$ _____

THE NUMBER OF WORK HOURS IN A WEEK GOES UNDER 20 FOR MEMBERS WHO ARE 18-50 IF THERE ARE NO CHILDREN IN THE HOUSE

NAME	NUMBER OF HOURS	WHERE WORKING
------	-----------------	---------------

IF YOU RECEIVE TANF, TELL US IF AN ELIGIBLE CHILD LEAVES YOUR HOME

Name	Date moved out	Name	Date moved out
------	----------------	------	----------------

CHANGES THAT MAY AFFECT VIEW PARTICIPATION FOR TANF. DISCUSS WITH YOUR VIEW WORKER.

Change that has occurred _____

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CHANGES YOU MAY WANT TO REPORT**CHANGE IN SHELTER EXPENSES**

Rent or Mortgage	Property Taxes	Homeowner's Insurance	Electricity
\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____
Gas	Oil	Kerosene, Coal, wood, etc. List and give amount	
\$ _____ per _____	\$ _____ per _____		
Water/Sewer	Garbage	Telephone (Basic Service Only)	Installation Fees
\$ _____ per _____	\$ _____ per _____	\$ _____ per _____	\$ _____ per _____

CHANGE IN DAY CARE EXPENSES

Person paying for care	Person receiving care	Amount billed	How often?
		\$ _____	

CHANGE IN MEDICAL EXPENSES FOR MEMBER WHO ARE 60 OR MORE OR DISABLED

Name	Type of expense	Amount billed
		\$ _____

CHANGE IN LEGALLY OBLIGATED CHILD SUPPORT PAID TO ANOTHER HOUSEHOLD

Person paying support	Person receiving support	Amount legally obligated	Amount paid
		\$ _____ per _____	\$ _____ per _____

CHANGE IN THE NUMBER OF PEOPLE IN YOUR HOUSEHOLD

Has ANYONE MOVED IN?

Name	Date moved in	Relationship to you	Social Security Number	
Date of Birth		Race (not required)	Sex	Marital Status
U.S. Citizen Yes () No ()	If Alien, give alien number, date of entry	Last school grade completed	Currently in School? Yes () No ()	

HAS ANYONE MOVED OUT?:

Name	Date moved out	Name	Date moved out

HOW LONG DO YOU EXPECT THE CHANGE(S) TO CONTINUE

() YES () NO Do you expect any of the change(s) you listed on this report to continue beyond this month? If YES, explain

I declare that all information I gave on this form is correct and complete to the best of my knowledge and belief.

Signature _____ Date _____

The Virginia Department of Social Services is an equal opportunity provider.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

INTERIM REPORT FORM - REQUEST FOR ACTION

Case Name: _____

Case Number: _____

Agency: _____

Date: _____

You were required to send in a completed Interim Report to this agency by the fifth (5th) of the month. Please note the information checked below.

- () We have not received an Interim Report form from you. A copy of the Interim Report is attached. When you send it in, please make sure you answer every question, attach all the information the report asks for, and sign and date the report.
- () The Interim Report form you submitted was incomplete. The form you submitted is attached. This form is incomplete because:
1. () You did not answer every question. Please answer the following questions: _____

 2. () Proof of some of the statements made on your report was missing, and without the proof we are requesting, the amount of food stamps or TANF you receive may be decreased or your case closed. Please send in the following proof: _____

 3. () You did not sign and/or date the report. Please sign and date the report.

You must return a completed Interim Report and proof of any changes within ten (10) days, by _____. If you do not submit a completed report by this date, your Food Stamp or TANF case may be closed or the amount of benefits you get may be reduced. You will not receive an additional notice unless the information you submit changes your benefits.

If you are unable to complete the Interim Report or if you have any questions about how to complete it or what information you need to send in, you may ask your local agency worker for help.

Worker	Telephone Number	For Free Legal Advice Call
--------	------------------	----------------------------

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APPEALS AND FAIR HEARINGS

If you do not agree with the action we are proposing or the amount of benefits you are receiving, you may have a fair hearing on your case. At the hearing you will have a chance to explain why you think we made a mistake and a hearing officer will decide if you are right. A hearing gives you a chance to review the way a local social services agency handled your situation about your need for TANF or food stamps. The hearing is a private, informal meeting at the local social services agency with you and anyone you want to bring as a witness or to help you tell your story, such as a lawyer. A representative of the local agency will be present as well as a hearings officer. The hearing officer is the official representative of the State Department of Social Services.

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you want free legal advice, you may contact your local legal aid office.

How to File an Appeal

- Send a written request for TANF appeals
 - Write to the Virginia Department of Social Services, Attention: Hearing and Legal Services Manager, 730 East Broad Street, Richmond, Virginia 23219-1849
- Either write or call for food stamp appeals
 - Call me at the number listed on the front; or call 1-800-552-3431
 - Write to the address above.

When to Appeal

- Within the next 30 days for TANF and within the next 90 days for food stamps.
- Within 10 days of the date on this form to get the food stamps continued.*
- Before the effective date of the change to get the TANF benefits continued.*

*Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

Local Agency Conference

In addition to filing an appeal, you may have a conference with your local social services agency. During the conference, the agency must explain its proposed action. You will have the chance to present any information where you disagree with the agency's proposed action. You may present your story by an authorized representative, such as a friend, relative, or lawyer.

If you request the conference within 10 days of receiving of your notice to decrease or end your TANF or food stamps benefits, the proposed action will not take place until after there is a decision made for the conference.

If the conference does not satisfy you and you want to continue to receive your benefits until there is a hearing decision, you must file an appeal for TANF benefits within two days following the date of the conference and within 10 days of the conference date for food stamps. If you do not ask for a conference but you file an appeal within 10 days of the notice of action to reduce, suspend, or terminate your TANF or food stamps, you may continue to receive benefits until there is a hearing decision. If you appeal the proposed action on your TANF case before the reduction, suspension or termination effective date, you may also receive continued coverage. Note that you may have to repay benefits you received during the appeal process if the hearing decision supports the agency action.

Hearing Process and Decision

The hearing officer will notify you of the date and time for your hearing at the local social services agency or at a location agreeable to you and the agency. If you cannot be there on that day, call the hearing officer and your eligibility worker immediately. If you need transportation, the local agency will provide it.

At the hearing, you and/or your representative will have the opportunity to:

- Examine all documents and records used at the hearing;
- Present your case or have it presented by a lawyer or by another authorized representative;
- Bring witnesses;
- Establish pertinent facts and advance arguments; and
- Question or refute any testimony or evidence, including the opportunity to confront and cross-examine witnesses.

The hearings officer will base the decision only on the evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In this event, you and the local social services agency would have the opportunity to question or refute this additional information.

You will get the hearings officer's decision in writing on your appeal within 60 days of the date the State Department of Social Services receives your appeal request.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
EMPLOYMENT SERVICES PROGRAMS
COMMUNICATION FORM

REGISTRANT _____
CASE NAME _____
CASE NUMBER _____

☐ FSET ☐ GR ☐ TANF ☐ TANF-UP

TO _____, EW
FROM _____, ESW

Date _____
Reply Needed By _____

☐ Reevaluation of non-exempt/mandatory status is requested
because _____

☐ Individual has failed to comply with program requirements.
Reason _____

☐ Volunteer no longer wishes to participate.
☐ Individual will enter/entered employment on ____/____/____
#Hours/week _____ Rate of pay \$ _____ Per _____
Employer _____

☐ Good cause does not exist.
☐ Notify ESW if aware of good cause reason.
☐ Comparability exists.

☐ Please send verification of employment.
☐ Individual will enter education or training activity
on ____/____/____
Location _____

☐ Sanction for (check appropriate answer):
____ until notified of compliance ____ 3 months and compliance
____ 1 month and compliance ____ 6 months and compliance

☐ Individual will be a participant in work experience. Please
provide the FS or GR dollar amount for the month of

☐ Please provide the dollar amount of reduction due to
employment or sanction.
☐ Please notify when sanctioned individual has been added
back to FS unit.
☐ Other _____

TO _____, ESW
FROM _____, EW

Date _____
Reply Needed By _____

☐ Result of reevaluation of non-exempt/mandatory status

☐ Effective with payment on ____/____/____, benefits
will be reduced
from \$ _____ to \$ _____

☐ Non-exempt/mandatory individual now exempt.
Reason _____

☐ Individual appealed sanction. Pre-hearing conference
scheduled for ____/____/____ at _____ (time).

☐ Volunteer no longer wishes to participate.
☐ Individual will enter/entered employment on ____/____/____
#Hours/week _____ Rate of pay \$ _____ Per _____
Employer _____

☐ Sanction ended effective ____/____/____
Mandatory registrant has been added back to FS unit.

☐ Individual/household no longer eligible for FS or GR.
Case closed due to: (check one)
☐ Sanction-ANPA sent
☐ Employment-Benefit reduction/savings information
provided below
☐ Other _____
Effective Date _____

☐ Amount of FS allotment/GR payment for
month of _____ was \$ _____

☐ Individual may be unable to participate in ESP/FSET
program because _____

☐ Individual deleted from FS household due to: (check one)
☐ Sanction, ANPA sent
☐ Other _____
Effective Date _____

☐ New certification period:
from _____ to _____

☐ Individual can: ☐ Read English ☐ Write English

☐ Other _____

10/95

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EMPLOYMENT SERVICES PROGRAMS COMMUNICATIONS FORM

FORM NUMBER - 032-02-072

PURPOSE OF FORM - To exchange information about ESP clients between the eligibility worker and the Employment Services worker.

USE OF FORM - To be originated by either the eligibility worker or the Employment Services worker at the time circumstances change, for the registrant, that require the exchange of information.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - This form is prepared in triplicate. Distribution of the top two copies is indicated on the form. The third copy remains attached to the copy being forwarded, in the event the receiving party uses the same form for reply.

INSTRUCTIONS FOR PREPARATION OF FORM

The name of the registrant, the case name, case number and program are to be entered in the upper right hand corner by the worker who originates the form.

The top half of the form is completed when messages must be communicated to eligibility staff from employment services staff. The employment services worker will check whichever block communicates the desired information or requests the desired information.

The bottom half of the form is completed when the eligibility staff is either returning the form to employment services with the requested information completed, or when the eligibility staff is communicating information to employment services. The eligibility worker will check whichever blocks are applicable to the situation.

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VOLUME V, PART XXV, APPENDIX III, PAGE i

FSET FORMS

<u>FORM NUMBER</u>	<u>NAME</u>	<u>PAGES</u>
032-01-921	Working Your Way to a Better Life Pamphlet	1-3
032-02-014	FSET Pre-Assessment Form	4-5
032-02-074/9	FSET Assessment Form	6-9
032-02-075/3	FSET Plan of Participation	10-12
032-02-077/4	FSET Job Search Form	13-15
032-02-081/4	FSET Work Site Agreement	16-17
032-02-080/2	Work Experience Position Form	18-19
032-02-082/5	Referral to Work Experience Site	20-21
032-02-083/2	Work Experience Attendance and Performance Record	22-23
032-02-083A/2	Time and Attendance Record	24-25
032-02-086/9	FSET Statistical Report	26-28
032-02-078/5	Contact Sheet	29-32
032-02-089/6	FSET Notice of Sanction	32-33
032-03-378/1	Medical Evaluation	34-36
032-02-072/7	EMPLOYMENT SERVICES PROGRAMS COMMUNICATION FORM	37-38

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
FOOD STAMP EMPLOYMENT AND TRAINING
(FSET) PROGRAM

REGISTRANT NAME: _____
CASE #: _____
DATE: _____

FSET PLAN OF PARTICIPATION

**PLANNED COMPONENT
ASSIGNMENT**

YES NO

Currently employed full-time

Currently employed part-time

Planned
Begin Date

Planned
End Date

Planned
Weekly Hrs

Job Search

Job Search Training

Work Experience

Education

Training

CURRENT PROGRAM ACTIVITY ASSIGNMENT

Program Activity Assignment

Description/
Location

Planned
Begin Date

Planned
End Date

Planned
Weekly Hrs.

☐ **PENDING** Dates: _____

☐ **INACTIVE** Dates: _____

List reasons for assignment to Pending or Inactive and the steps necessary to resolve problem: _____

SUPPORTIVE SERVICES

☐ Day Care ☐ Transportation ☐ Other (please describe) ☐ None

Participant responsibilities for current component assignment(s): _____

Agency responsibilities: _____

PARTICIPANT OBLIGATIONS

I understand that I am responsible for keeping the agency informed of my progress and needs. I agree to call the worker/case manager whose name is listed at the bottom of this page if I have a problem that makes it impossible to keep an appointment or if I wish to discuss or change an activity. I agree to continue in my current activity until I have discussed any problem I may have with my worker/case manager.

I understand that if I fail to participate without a good reason my Food Stamp case may be reduced or closed.

☐ **FOR PARTICIPANTS ASSIGNED TO COMPONENTS**

I will carry out the responsibilities as agreed.

☐ **FOR PARTICIPANTS ASSIGNED TO PENDING**

I understand that I am not actively participating at this time, but that I must answer all calls and letters from agency staff since I may be required to participate in the future.

☐ **FOR PARTICIPANTS ASSIGNED TO INACTIVE**

I understand that I will not actively participate at this time. I also understand that I must answer all calls and letters from agency staff since I may be required to participate in the future.

PARTICIPANT'S SIGNATURE _____ **DATE** _____

CASE MANAGER'S SIGNATURE _____ **PHONE** _____

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
EMPLOYMENT SERVICES PROGRAMS
COMMUNICATION FORM

REGISTRANT _____
CASE NAME _____
CASE NUMBER _____

☐ FSET ☐ GR ☐ TANF ☐ TANF-UP

TO _____, EW
FROM _____, ESW

Date _____
Reply Needed By _____

☐ Reevaluation of non-exempt/mandatory status is requested
because _____

☐ Individual has failed to comply with program requirements.
Reason _____

☐ Volunteer no longer wishes to participate.

☐ Good cause does not exist.

☐ Individual will enter/entered employment on ____/____/____
#Hours/week _____ Rate of pay \$ _____ Per _____
Employer _____

☐ Notify ESW if aware of good cause reason.

☐ Comparability exists.

☐ Please send verification of employment.

☐ Sanction for (check appropriate answer):
____ until notified of compliance ____ 3 months and compliance
____ 1 month and compliance ____ 6 months and compliance

☐ Individual will enter education or training activity
on ____/____/____
Location _____

☐ Please provide the dollar amount of reduction due to
employment or sanction.

☐ Individual will be a participant in work experience. Please
provide the FS or GR dollar amount for the month of

☐ Please notify when sanctioned individual has been added
back to FS unit.

☐ Other _____

TO _____, ESW
FROM _____, EW

Date _____
Reply Needed By _____

☐ Result of reevaluation of non-exempt/mandatory status

☐ Effective with payment on ____/____/____, benefits
will be reduced
from \$ _____ to \$ _____

☐ Non-exempt/mandatory individual now exempt.
Reason _____

☐ Individual appealed sanction. Pre-hearing conference
scheduled for ____/____/____ at _____ (time).

☐ Volunteer no longer wishes to participate.

☐ Sanction ended effective ____/____/____
Mandatory registrant has been added back to FS unit.

☐ Individual will enter/entered employment on ____/____/____
#Hours/week _____ Rate of pay \$ _____ Per _____
Employer _____

☐ Amount of FS allotment/GR payment for
month of _____ was \$ _____

☐ Individual/household no longer eligible for FS or GR.
Case closed due to: (check one)

☐ Sanction-ANPA sent
☐ Employment-Benefit reduction/savings information
provided below

☐ Individual may be unable to participate in ESP/FSET
program because _____

☐ Other _____
Effective Date _____

☐ New certification period:
from _____ to _____

☐ Individual deleted from FS household due to: (check one)

☐ Sanction, ANPA sent

☐ Individual can: ☐ Read English ☐ Write English

☐ Other _____
Effective Date _____

☐ Other _____

10/02

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EMPLOYMENT SERVICES PROGRAMS COMMUNICATIONS FORM

FORM NUMBER - 032-02-072

PURPOSE OF FORM - To exchange information about ESP clients between the eligibility worker and the Employment Services worker.

USE OF FORM - To be originated by either the eligibility worker or the Employment Services worker at the time circumstances change, for the registrant, that require the exchange of information.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - This form is prepared in triplicate. Distribution of the top two copies is indicated on the form. The third copy remains attached to the copy being forwarded, in the event the receiving party uses the same form for reply.

INSTRUCTIONS FOR PREPARATION OF FORM

The name of the registrant, the case name, case number and program are to be entered in the upper right hand corner by the worker who originates the form.

The top half of the form is completed when messages must be communicated to eligibility staff from employment services staff. The employment services worker will check whichever block communicates the desired information or requests the desired information.

The bottom half of the form is completed when the eligibility staff is either returning the form to employment services with the requested information completed, or when the eligibility staff is communicating information to employment services. The eligibility worker will check whichever blocks are applicable to the situation.